



CIVIL SOCIETY FUND
Strengthening Civil Society for Improved
HIV/AIDS and OVC Service Delivery in Uganda



**FACTORS AFFECTING MALE INVOLVEMENT IN FAMILY PLANNING IN COMMUNITIES
AND POPULATIONS SERVED BY CSF SUPPORTED ORGANIZATIONS**

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OPERATIONAL DEFINITIONS

Family planning (FP): In this study FP was defined as use of contraceptive methods (especially modern methods) to control conception or regulate the number, spacing and timing of children for partners (male and female) or individuals who may not necessarily be in long lasting relationships.

Male involvement: For purposes of this study male involvement was defined as the active role men play in both decision-making and behaviors, such as sharing reproductive decision-making with their female partners, and supporting their partner's choices. In addition the definition of male involvement included the use of any or all of the male modern methods of contraception like condoms, and vasectomy to control the number, spacing and timing of children in a sexual relationship (Mundigo, 2000).

CSO beneficiaries: These were people that received reproductive health services from CSF supported CSOs in the different sub regions.

LIST OF ABBREVIATIONS AND ACRONYMS

CSF	Civil Society Fund
CSOs	Civil Society Organizations
FGDs	Focus Group Discussions
FHRDC	Family Health Research and Development Centre
FP	Family Planning
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IRB	Institutional Review Board
KIIs	Key Informant Interviews
MakSPH	Makerere University School of Public Health
MOH	Ministry of Health
PMTCT	Prevention of Mother-to- Child Transmission
RA	Research Assistant
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNCST	Uganda National Council for Science and Technology

EXECUTIVE SUMMARY

Introduction and background: Globally, at least a third of all pregnancies are unplanned, resulting in high rates of unsafe abortions especially in developing countries. In Uganda, a country with a high total fertility rate (TFR=6.2), about three quarters (755,000) of women get unintended pregnancies annually (UDHS 2011). The high number of unwanted pregnancies and TFR suggest a low uptake of family planning (FP). Although Contraceptive Prevalence Rates (CPRs) for modern FP methods has increased in the past 5 years from 18 % to 24% (UDHS 2011), the use of male controlled methods (male condoms) or the support of their partner's use of FP methods are still limited. Previous studies have showed that enhancing partner/spousal communication about FP can increase male involvement in FP, which in turn can improve CPR and reduce the number of unplanned pregnancies. Over the years, a number of civil society organizations and programs have provided sexual and reproductive health services, including FP. Unfortunately CPR has continued to be low or suboptimal, and contribution of male involvement in FP and the factors associated with this involvement are not fully known.

Objectives: To determine the level of and factors associated with male involvement in FP in communities and populations served by CSF supported civil society organizations (CSOs)

Methodology: A total of 873 randomly selected females (18-49 years) and males (18-54 years) in communities and populations served by selected CSF supported CSOs were interviewed in this cross sectional study that utilized both quantitative and qualitative methods. In the qualitative component 16 male and female focus group discussions (FGDs) and 37 Key Informants (KIs) interviews were conducted. The study was implemented in 15 districts clustered in 7 regions based on the Uganda national sero-survey regions. Male involvement in FP was defined as the use of a modern male method (male condom/vasectomy) or discussing with the partner about FP use or the male partner being part of a decision to use a FP method.

Results: The study population was highly sexually active, 86.3% reported having had sexual intercourse in the past 12 months. The prevalence of pregnancy was reported at 12%, but 11% of the currently pregnant women had tried to terminate the pregnancy. Close to three quarters (73.6%) of the non-pregnant women wished to limit (48.1%) or delay childbearing for at least two years (25.5%). Just over a half (53%) of the respondents reported use of FP method at the last sexual encounter, higher among male (61%) than female (50.2%) respondents. The most commonly

mentioned FP methods were hormonal (31.9%), and male condoms (12%). Use of traditional methods was reported to be 6%. Government (50.8%), private facilities (19.3%) and drug-shops (11.0%) were the commonest sources of FP methods in this setting. The overall prevalence of male involvement in FP was 45% at last sexual encounter, significantly higher among male (56%) relative to female respondents' reports 41%. A statistically significant variation in male involvement was observed in the surveyed regions ($p=0.020$; 95%CI (0.0025, 0.1487), $p=0.057$) and within communities $p=0.10$; 95%CI(0.0432, 0.2161), $p<0.001$. Male involvement was highest in the Eastern, 56.3% and lowest in West-Nile, 32.4%. The corresponding level of unmet need for FP was 31.6% in the Eastern, and 55.6% in West-Nile. However, the South-West had the lowest level of unmet need for FP at 25.6%, and the highest level of desire for another child at 40.5%. The Northern region had the lowest (13.2%) desire for another child and a corresponding unmet for FP at 30%. Important factors known to be associated with FP uptake that varied by region included social economic status (SES), , level of respondent schooling and total number of child. Respondent age also varied considerably across study regions; female age, mean (SD) 32.9 (14.0) years in East-Central and 28.9 (8.5) in the South-Western regions, while male mean age varied from 33.7(8.9) years in Eastern to 28.2(9.6) in the North. In this study, quality of services as measured by high client perceived satisfaction of the FP services, provider competency, and health workers' positive attitudes towards male involvement in FP, as well as female partners desire to have their male partners participate more in FP activities were important factors associated with increased male-involvement in FP. Also male involvement was significantly higher in non-marital relationships, adj.RRR=1.94 (1.43, 3.32); having had talks about FP, adj.RRR=2.72 (1.71, 4.33); being aware of HIV care services availability in the community, and increasing level of schooling, post-primary level of educations relative to no-schooling, adj.RRR=2.05 (0.85,4.94). Barriers to male involvement included misconceptions, negative beliefs about FP and a fertility high desire. Other key barriers included respondent being in a marital disrupted relation (divorced/separated/widowed) compared to never married, adj.RRR=0.26 (0.10, 0.73), large family size (6+ co-resident children aged less than 15 years) compared to smaller family sizes (2 or fewer co-resident under 15 year old children), low social economic status, adj.RRR=0.56 (0.32, 0.98), and being pentecostals/SDA faith compared to Catholics, adj.RRR=0.53 (0.27, 1.06). Men perceived the role of FP in HIV prevention as being relevant through use of male condoms. Civil society organizations (CSOs) also endeavoured to involve men in FP, but with varying strategies.

Conclusions: The level of male involvement in FP was moderate (45%), but varied significantly by study region. Factors facilitating male involvement in FP included awareness about HIV care services within study communities, knowledge about FP and higher levels of schooling (education) especially post-primary and client perceived quality of FP services . Barriers were perceived and actual side effects experienced by FP users and the high community misconceptions about modern FP methods. Quality of FP services/commodities was perceived as being satisfactory but providers did not ask clients about their FP choice which affects perceived quality of FP care.

1. INTRODUCTION

Over the past three decades, developing countries have made substantial progress toward improving maternal and child health, providing reproductive health services including FP to couples, and bringing fertility and mortality levels in line with national goals (UNAIDS 2005). While the HIV/AIDS pandemic has had a dramatic impact on the health, growth and composition of seriously affected populations, high fertility remains the dominant factor dictating the future size, growth, and composition of most developing nations. For example, Uganda's population growth rate of 3.4% per annum is entirely a result of natural increase (Population Reference Bureau 2011).

According to the UDHS 2011, Uganda has a TFR of 6.2 children. In Uganda, about 755,000 women get unintended pregnancies each year and every year about 297,000 women have unsafe abortions and 85,000 suffer from complications. Also 34% of married women wish to space their pregnancies or want to stop child bearing altogether but are not using FP methods (Uganda Bureau of Statistics and ICF Macro 2012). Every year in Uganda about 6,000 women die as a result of pregnancy related complications and a significant proportion of these deaths occur because women are not able to have healthy planned pregnancies. Uganda has a high maternal mortality rate; 438 deaths for every 100,000 live births and this is the equivalent of about 6,000 women dying each year. Many of these deaths can be prevented if FP methods are consistently and correctly used by couples.

The correlation of FP and HIV prevention has been well documented over the years (Tsui, McDonald-Mosley et al. 2010). Evidence shows that successful FP services can prevent mother-to-child transmission of HIV by helping infected women avoid unwanted pregnancies (Keogh, Urassa et al. 2009). Furthermore, contraceptive barrier methods, such as male and female condoms, protect against sexual transmission of the virus. But despite the potential of FP methods to prevent HIV/AIDS, most HIV/AIDS prevention and care efforts are being designed and implemented as separate programs. This greatly hampers the implementation of interventions benefits for the would be synergies such as building multiple strategic partnerships, linkages and referral systems that are mutually supportive to promoting increased male involvement in FP.

1.1 Male involvement in FP

In the developing countries, only a quarter of the people who use contraceptives for FP rely on male methods (United Nations 2009). In the past decades, although there has been overall increase in the level of contraceptive prevalence or in the FP use, low use of male methods has remained static in most of the developing countries. This status quo is also highlighted in both the 2006 and 2011

Uganda Health and Demographic Surveys. Knowledge of some male methods of FP has also remained low. In the 2011 UDHS, knowledge of any method of contraception is universal among married men in Uganda. However, married men have a higher knowledge of the female methods of FP compared to some of the male methods. This contributes to the low use of these male methods.

Male involvement in FP could include giving permission to women (partners) to use contraception and/or promoting contraception for other men. This is influenced by attitudes of men towards FP, which are very vital if their involvement and use of contraception is to be enhanced. Men's attitudes and beliefs have not been well studied although from their practices, the direction of attitudes and beliefs could be inferred. Men's discussions with their partners (spousal communication) about FP in Uganda have generally been poor (Kaida A, Kipp W et al. 2005). Almost half of married women had not discussed FP with their partners in the last one year in the 2006 UDHS. Further, among married women using contraception, 17% were using it without their husband/partner's knowledge (Uganda Bureau of Statistics and Macro International Inc. 2007).

Men are key players in FP because many couple reproductive health decisions in developing countries are made by the male partner. Many women either rely on the advice of their male partners on issues such as using FP and having another child or engage in joint decision-making with them (Adewuyi and Ogunjuyigbe 2003). There is a high likelihood that men can actually use or support their partners' use of contraceptive if they are given adequate information, education and communication (IEC) about the need and ways to regulate fertility.

The programme of action adopted by the International Conference on Population and Development (ICPD) held in Cairo 1994 notes that male involvement constitutes special efforts made to emphasize men's shared responsibility and their active involvement in responsible parenthood; shared responsibility in sexual and reproductive behaviour, including FP (FP); pre-natal, maternal and child health; prevention of HIV and other Sexually Transmitted Infections (STIs); and prevention of unwanted and high-risk pregnancies. The use of male FP methods like condoms, coitus interruptus, rhythm and vasectomy are examples that highlight proactive male involvement in FP. However, worldwide, only 15 percent of users of FP rely on the male condoms, male sterilisation and coitus interrupts and rhythm methods of FP that to a great extent require full male cooperation (UN Population Division, 2009).

According to Carlos in 1984, it is contended that programmes can serve family needs better by addressing women as well as men's fertility desires, goals and attitudes. Like in HIV/AIDS, men need to share the responsibility of disease prevention as well as the risks and benefits of contraception (Wegner et.al. 1998). Kiada et al 2005, also advocate for a more couple oriented approach to FP in their study because even though they found men to have positive attitudes, they were not involved in FP. It therefore, implies that failure to involve men in FP can have serious implications.

Ensuring male involvement in reproductive health services including FP can be health care provider initiated and this requires positive attitudes from FP service providers to this initiative. This strategy has been used in involving men in maternal health services like ANC and PMTCT in some countries. Another strategy used is to provide first and fast care to women who come with their male partners for service provision. However this is not always possible especially when there are large numbers of men involved with their partners. The other strategy is for health care providers to explain to the woman seeking services the benefits of involving their partner in their reproductive health care and issues. Where this is done, usually a notification card is given to the woman to take to the spouse. This proved effective in a study done in Malawi where almost all men invited through this method came to the health facility (Kululanga, Sundby et al. 2011). Recruiting more male FP providers may also encourage more men to take up the FP services as these can easily influence fellow men to use and promote contraception (Kaida A, Kipp W et al. 2005).

Upon recognition that limited male involvement is one of the key factors that are responsible for limiting women's access to FP, Civil society fund (CSF) has emphasized the promotion of access to and utilization of FP services and other sexual and reproductive health services to both men and women who are in need of them through its supported civil society organizations (CSOs). CSF emphasizes that all sub grantees, men and women who are engaged in HIV prevention as well as care and treatment interventions integrate FP and sexual and reproductive health services in their programs. CSF needs to support organizations that support and promote FP especially in rural areas.

1.2 Problem Statement

Since inception, the CSF has been committed to supporting all sub grantees who are engaged in HIV prevention as well as care and treatment to meaningfully integrate FP in their programs. This will catalyse the scaling up of FP services to all men and women in need these services. Through the contracted CSOs, CSF has been supporting and emphasizing the promotion of access to and utilization of FP services among both men and women who are in need of them. Despite this commitment, the reports indicate that the current national uptake of any modern FP among married women is only 26% (UDHS 2011-Preliminary report). This is still low though on course to the national target of 35% by 2015 (Ministry of Health 2010). The current use of male methods of FP in Uganda is also very low. According to the 2011 UDHS, only 0.1% of currently married women have partners who have had male sterilization, 2.7% use male condoms regularly, 1.4% use periodic abstinence and 2.1% use withdrawal method. The aforementioned status quo thus provides an overall uptake of male related methods of only 6.2%. Despite the CSF supported CSO sub-grantees provision of sexual, reproductive health and FP in a number of communities and populations, there is limited data on the level of current male involvement in FP in such served communities. Also, data on factors contributing to such levels of male involvement in these communities are not fully known.

Results presented here will therefore provide CSF with a better understanding of the level of male involvement in FP and the socio-economic context that may or may not affect this involvement. Behaviors and barriers that affect uptake of FP services and other male involvement facets in FP from the males and their partners' point of views will be studied. In addition, feasible and effective strategies that increase and promote male involvement including uptake of FP services are explored. An understanding of these factors will inform appropriate strategies and interventions that will increase male involvement and uptake of FP services

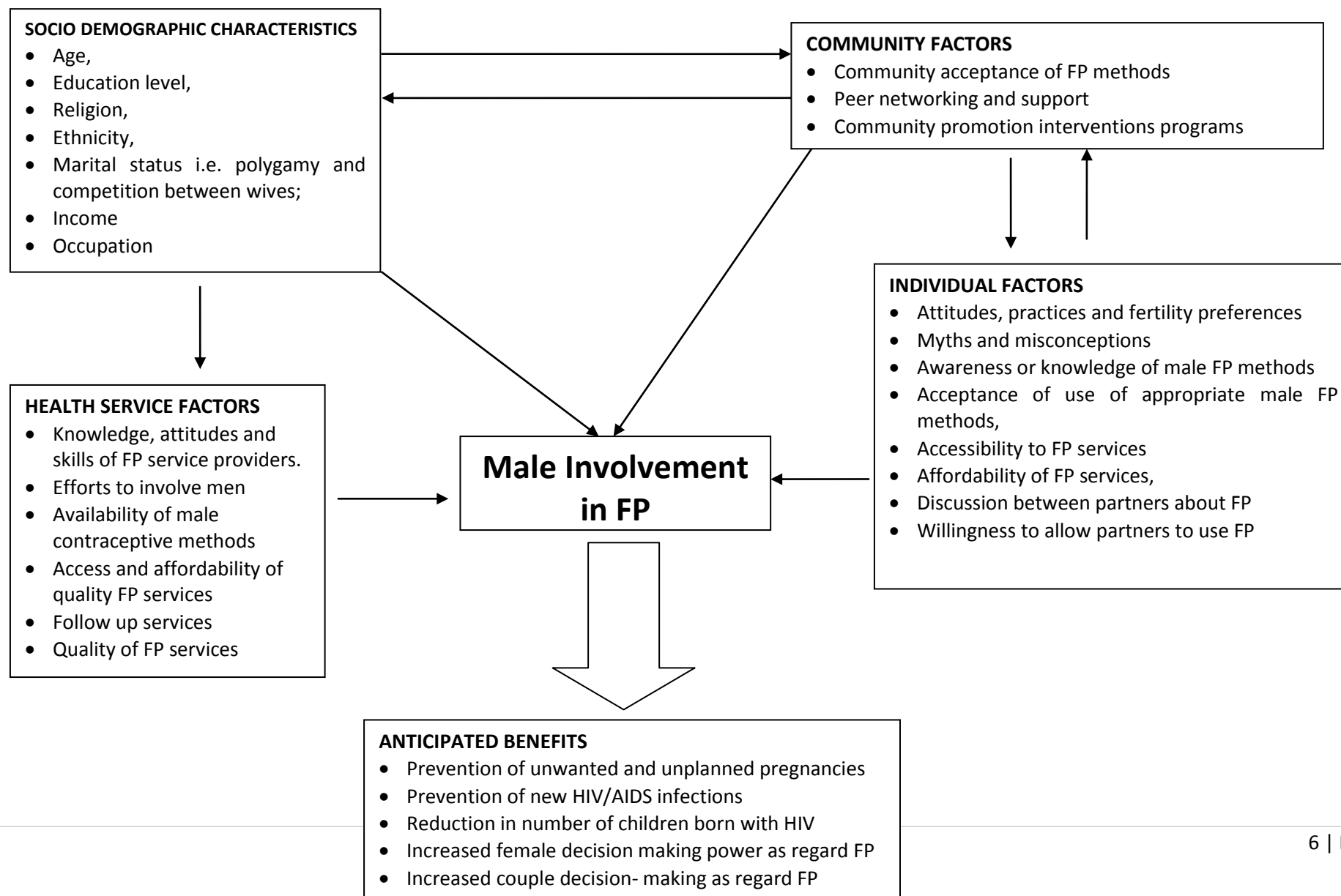
1.3 Justification

The male methods of FP can significantly contribute to increase the contraceptive prevalence rate if their uptake and utilization is scaled up in society. The male methods have minimal side effects compared to other methods. In the presence of HIV/AIDS, male FP methods like condom use would bear significant results in both preventing unwanted pregnancies and transmitting HIV and other STIs. These methods require a lot of the men's cooperation if they are to yield their intended benefits especially due to the fact that in Uganda, society (both men and women) regards men as

having the ultimate decision on the number and spacing of their children and many times decisions in the households and among partners are made by the men. This invariably has the potential to affect women's access to and utilization of FP services (Kibira 2009). Therefore understanding the level of knowledge, attitudes, beliefs and practices of men towards various aspects of FP is very crucial in scaling up male involvement in FP services.

This study therefore explored the factors affecting the involvement of men in FP, by focusing on the beneficiaries in the CSF-supported CSOs. This information will be used by the CSF sub grantees and potentially other NGO led FP programs to design interventions/strategies that will be used to scale up male involvement in FP in order to harness the associated benefits. These include but not limited to preventing unwanted pregnancies which tend to result in abortions; encouraging their spouses to use contraceptives; using FP themselves; advocating and influencing other men to using FP and preventing the transmission of HIV and other STIs from the infected individuals to their partners.

1.4 The conceptual framework for the factors affecting male involvement in FP in the CSF supported CSOs



1.5 Research question

What are the factors that affect male involvement in FP in CSF supported civil society organizations communities and population?

1.6 Objectives of the study

1.6.1 Overall Aim

The overall aim was to determine the level of male involvement in FP and the factors that are associated with male involvement in FP in communities and populations served by CSF supported civil society organizations in Uganda.

1.6.2 Specific objectives

1. To determine the level of male involvement in FP
2. To assess attitudes and beliefs of men and women towards male involvement in FP
3. To assess the knowledge, attitudes and beliefs of men towards the various modern FP methods used by women
4. To explore the female partner's perceptions on male involvement in FP and use of male methods.
5. To assess the men's perception of the relevance of FP in HIV prevention and whether they would promote FP for their partners.
6. To assess the current attitudes among service providers in providing FP services to the men.
7. To assess the status of the efforts undertaken by the CSO's FP programmes to involve men in FP.

2 METHODOLOGY

2.1 Study design

This was a cross sectional study which employed both quantitative and qualitative methods. The quantitative survey enabled the research team to determine the level of male involvement in FP and the factors associated with their involvement in FP. The qualitative aspect complimented the quantitative survey in further understanding the factors associated with male involvement in FP in communities and populations served by the CSF supported CSOs.

2.2 Study site

The study was conducted in all the 8 regions where CSF operates, i.e. Northern, North East, West Nile, South western, Mid-western, Eastern, East central and Central region.

2.3 Study population

The primary study population were adult males (18-54 years) and females (18-49 year), CSO staff and the FP service providers in communities and population served by CSOs.

2.4 Quantitative component

2.4.1 Inclusion criteria

- Adults males aged 18-54 years or females aged 18-49 years, and resident in the randomly selected CSO served communities/population
- FP service providers in the communities/populations the CSOs provide services
- CSOs that provide sexual and reproductive health services including FP either as their primary focus or as an integral part of their activities

2.4.2 Exclusion criteria

- Potential eligible respondents who were not willing or not able to provide an informed consent or too ill to participant in the study.

2.4.3 Sample size determination:

The sample size for the quantitative cross sectional survey component was estimated using the Kish Leslie formula, with the following key assumptions;

$$N = Z^2_{(1-\alpha/2)} * p * q / d^2$$

Where N = required sample size

$Z^2_{(1-\alpha/2)} = 1.96$ (The Z-score at two-sided standard normal distribution at 95% confidence, or with 5% type I error rate)

p = the assumed proportion of male involvement in FP among respondents in communities/populations served by CSOs in the areas of sexual and reproductive health including FP. We assumed ~15% male involvement based on proportion of women reporting male methods (traditional and modern, 10%) and assuming a 5% of females users of female controlled methods whose male spouses/partners could have been aware /had discussed with them use of these methods (Uganda Bureau of Statistics and ICF Macro 2012)

$$q = 100\% - p \text{ (100-15= 85 \%)}$$

d = required precision of the estimate, assumed at 3% (this level of precision is high because data are limited on this estimate in the current literature. Also, this precision would still be valid and appropriate if the male involvement was to be 10% when only “use of methods” without the inclusion of the discussion component as highlighted in the operational definition of male involvement)

Inserting into the above formula, the required sample size therefore was 545 respondents

However, the respondents were obtained from different regions and CSOs with varying intensity of FP programs. This could potentially have led to clustering; where male involvement is similar within a region/CSO, but different from the other regions/CSOs because of the intra-cluster correlation of the outcome, male-involvement with respondent of the same cluster/strata. This clustering suggests a need to use a design effect (DEFT), assumed at 1.2-1.5. The assumed DEFTs are based on what is observed in the UDHS 2006 on the ever use of condoms for FP among various national regions. We therefore opted to assume the maximum DEFT of 1.5. Therefore the adjusted sample size was $545 * DEFT = 545 * 1.5 = 818$ respondents.

Taking into account a non-response rate of 10%, a final sample size of $818/0.9=909$ was obtained.

2.4.4 Number of villages to be visited

Based on the UBOS approach, we decided to allocate 25 households from each selected village. Using the estimated sample size of 909 respondents, this resulted into approximately 36 villages ($909/25$). At total of 7 regions (*excluding the North East which had only 2 CSOs in the same district*) based on CSF operations were mapped out as shown in Table 2.1. We applied a probability proportion to size (PPS) approach to determine the number of villages/clusters per region based on CSOs in each region. We determined to have approximately (\sim) 2-3 villages per selected district, thus resulting into 15 districts for the survey.

2.4.5 Sampling

a) District Selection

These were purposely selected from each region to accommodate logistical feasibility (since it was correctly anticipated to be a heavy rainy season). Previous experience had shown that many murram roads are inaccessible in such seasons thus creating a huge challenge for activities in the communities especially those with hard terrain. Also, we ensured that at least one of the selected districts in each region had a CSO with integrated SRH or had SRH as the primary focus of the activities.

b) Sub-county and village selection

Within each selected district, a list of sub-counties where CSOs operate was generated and a random sample of one such sub-county was obtained by use of simple random sampling (SRS). In each selected sub-county a list of villages, which had CSO activities was obtained as a sampling frame. Then using simple random sampling (SRS) without replacement a total of 2 or 3 was randomly selected within that sub-county. The number of villages, each of size 25 respondents, per district was already determined as shown in Table 2.1.

Table 2.1: Selection of Districts and Villages

	Inter-grated	SRH	Area of Focus Total	Villages	Districts
Total	277	230	507	~36	15
Region					
Central	68	65	133	9	3
East Central	31	26	57	4	2
Eastern	68	38	106	8	3
Mid- Western	40	31	71	5	2
North	29	26	55	4	2
North East	2	0	2		-
South Western	28	32	60	4	2
West Nile	11	12	23	2	1

c) Selection of actual participants for the survey

A list of all households within each selected village was obtained from the Local council chairpersons or/and Village Health teams (VHT) members. Where the total number of all households in the sampling frame was between 20-30, all households were contacted for the interviews if a potential eligible study person existed. In the event that the number of households in the sampling frame was more than 30 households, a systematic sampling technique was conducted by obtained a sampling interval, “k” which was determined as the total number of households in the selected village divided by estimated sample size of 25 respondents per villages. With a random start on the sampling frame, every k^{th} household on the list was sampled a final size of 40 households was obtained. The extra households were sampled from the village list at this stage as potential “replacement” households for cases where the originally selected household did not have any potential eligible respondent. The study team took note of such households using a household verification form.

d) Selection of a study participant within household

A mini-household survey was carried out for all household members. Using the *KISH Grid* (Kish Leslie, 1965), all permanent household residents, males aged (18-54 years) and females (18-49 years) were ranked in descending order of age starting with all the eligible males and followed by females. All eligible household members were checked against the Kish Grid Table. The household member who had the eligible ordered number (rank) on the Kish Grid was selected as the respondents. For instance, in the mini-census table below (Table 2.2), a total of 6

eligible members were obtained. Table 2.3 (Kish Grid) shows the corresponding household eligible adult No (4) as the random study participant.

Table 2.2: For of a Mini-household census

Relationship	Sex	Age	Adult No.	Selection
Head	M		2	
Wife	F	45	5	
Head's father	M		1	
Son	M		3	
Daughter 1	F		6	
Daughter 1	F	25	4	✓

Table 2.3: Selection table

If the number of adults in the household is:	Select adult numbered:
1	1
2	2
3	2
4	3
5	4
6 or more	4

2.5 Qualitative component

2.5.1 Selection of actual participants for the qualitative component

The CSO beneficiaries who participated in qualitative data collection (Focus Group Discussions -FGDs) included; the CSO staff, the FP providers and the other key informants like opinion leaders and community leaders. These were selected by purposive sampling depending on their ability to provide insightful information on the study topic (Dawson S, Manderson L et al. 1993; Marshall 1996).

a) Focus Group Discussions

Four FGDs in were held in each of the four regions. This resulted in having a total 16 FGDs with both the adult male beneficiaries and females. Participants in the FGDs were clustered in 4 age and gender specific groups; young males (aged 18-24 years); older males (aged 25 years and above), young females currently in a relationship (aged 18-24) and older females currently in a relationship and aged 25 years and above. Each FGD had between 6 to 10 participants. Table 4

below shows the distribution of FGDs by region. Participants were mobilised in the same villages where the quantitative survey was carried out and where there were a number of CSOs in the vicinity..

Table 2.4: Selection of FGDs

Category of FGD	Masaka	Mbarara	Iganga	Lira	TOTAL
Male (18-24)	1	1	1	1	4
Females (18-24)	1	1	1	1	4
Male (25 plus)	1	1	1	1	4
Females (25 plus)	1	1	1	1	4
Total	4	4	4	4	16

b) Key informants

Key informants selected and interviewed included; the crucial staff of the CSO involved in FP programmes like managers, the key FP service providers (like counsellors, clinical officers, doctors, midwives, nurses, in charges of facilities and units). The opinion leaders who included local council (LC) leaders, religious leaders and VHTs were selected from the areas where the FGDs and the survey were conducted. The principle of data saturation was applied to sampling key informants for the study(Marshall 1996). Ultimately 34 Key informants were interviewed for this study.

2.6 Data collection methods

The survey used a structured quantitative survey tool with pre-coded responses while qualitative data were collected among the beneficiaries using FGD guides and KII guides. A review of literature was done to provide more information on male involvement and factors associated as well as services provision.

2.7 Measurement variables

2.7.1 Dependent variable

The primary outcome variable for this study was “*male involvement*” in FP. A male was categorized as being “involved” in FP if he regularly shared reproductive *decision-making* with his partner(s)/supported his partner’s choices, discussed FP use with partner or used male condom for FP. This could have been as reported by the female respondents in the survey or as

reported by the selected male participant. In addition, a male beneficiary was categorized as being “involved” in FP if he regularly used any of the male FP methods including contraception such as condoms, coitus interruptus, rhythm and vasectomy/male sterilisation, or if the female reported regular use of such methods with her primary male partner. A composite measure of “male involvement” was constructed based on the positive response on either or both of the two categories; either the use of *male methods/sharing the reproductive decision-making focused at FP use/discussing with the partner on the use of FP*. Data on use of female methods-only, male-involvement as defined above or none FP use were categorized as the outcome for these analyses.

2.7.2 Factors associated with FP services/commodities

- 1) Individuals’ socio demographic characteristics such as; age, tribe, education level, religion, occupation, socio economic status and marital status
- 2) Health service variables like: perceived health workers’ attitude, client perceived quality of FP service, source of contraceptive commodities.
- 3) Individual’s knowledge, attitude and practices variables like: knowledge or awareness, attitudes, beliefs, practices, perception of the relevancy of FP, accessibility, and attitude towards male FP methods

2.8 Data management

2.8.1 Quantitative Data

Completed data tools were reviewed by the field data editor, collected by the field team supervisor and locked the completed tools into secure transportation boxes. Each data form was identified using unique identifications constructed as “***Region-CSO#-Participants # on sampling frame***”, but without respondents names so as to further ensure confidentiality as indicated in the informed consent. Data were 100% double entered using screens developed in the CSPro, and both files compared to ensure consistency in data capture. These had built-in consistency checks designed as a data control mechanism. The data entry was conducted at a secure office at the School of Public health *Family Health Research and Development Center*

(FHRDC) data management offices (MakSPH_FHRDC) in Kasangati. All electronic data were backed up on flash drives each day. A daily archive was saved both on a pass-word protected external drive and a protected directory on a MakSPH server. All the hardcopies of the completed data collection tools were secured under lock and key and are only accessed by key data management team members.

2.8.2 Qualitative data

All audio recordings and field notes and transcripts were submitted by the RAs to the MakSPH-FHRDC data management offices. The data was then transcribed verbatim, digitised and entered into Atlas.ti for coding. The coded transcripts were backed up at the end of each coding session.

2.9 Quality control

Research assistants (RAs) were recruited from a well established network of experienced RAs that have worked with the School of Public health on various research and consultancy protocols. In addition, MakSPH graduates and experienced undergraduate students with required qualifications were also be recruited as RAs. As a means of ensuring ethical and quality data collection, all RAs were trained for five days on research methods and conducting ethical research for this study. A pre-test was conducted as part of training. The data quality control system also included field data editors who reviewed every form that was subsequently noted upon the field data editor capture dates. This was done to ensure data completeness. In addition the quality control (QC) team conducted a sample of re-interviews to determine the consistency and accuracy of the data. The data collection team was supervised on a daily basis by a field supervisor during the two weeks of data collection. All the logistics were planned and implemented by field coordinators. The senior investigative team made regular field supervision and provided technical support on all aspects of the study. The senior investigative team worked very closely with the CSF assigned team leader to ensure that all the objectives were fully followed up. Furthermore there was triangulation of methodologies; qualitative and quantitative (FGDs, KIIs and survey) both in the field and at analysis to ensure that all objectives were fully answered.

2.10 Data Analysis

2.10.1 Quantitative data statistical analysis

The electronically captured data were transferred into STATA version 12 (Copyright 1985-2011 Stata Corp LP) for statistical analyses. Exploratory data analyses focusing on univariates were conducted which enabled the generation of frequency tables and other descriptive statistics. Measures of central tendency (means, median) and variation (standard deviations, inter-quartile range) were used for continuous data such as age and number of household members. For the categorical variables, proportions and where appropriate graphs were plotted. For the bivariate analyses, each explanatory variable tabulated against the outcome/dependent variable to assess any statistical associations. Where the explanatory variables were categorical the chi-square test and p-values with a cut-off point of 5% to determine statistical significance were used. The measures of association between the dependent and explanatory variables were the odds ratio or relative risk ratio (RRR), with their respective 95% confidence intervals. The multinomial logistic regression model was applied to obtain the RRR of male-involvement for the various risk factors. Further analyses were conducted using the multivariable multinomial regression to ascertain independent associations after adjusting for actual and potential confounders. Interaction terms were also tested and maintained in the final model or stratified analyses conducted if this provided more parsimonious models. Inclusion of variables in the multivariable models depended on $p < 0.15$ in the unadjusted models, or those that were potential confounders, and other already known associated factors from literature. Because we had applied a design effect in the sample size determination, we accounted for this in the analysis by use of clustering at the lowest level (which was the village) in this case to provide more precise standard errors for the various estimates.

2.10.2 Qualitative data analysis

All qualitative data was logged into Atlas.ti (version 6.2), electronically coded, query reports run and read through to closely examine issues that commonly appeared in the transcripts (Graneheim and Lundman 2004). We analysed the data using manifest content analysis technique. This type of analysis refers to a process where analysis of the appearance of particular

content in textual material is done. Description of the visible, obvious components of text and what the text says in the transcripts was taken into account in the coding process.

2.11 Ethical considerations

Ethical approval was sought from Makerere University School of Public Health Higher Degrees Research and Ethics Committee (a local IRB) and then Uganda National Council of Science and Technology (UNCST). Introduction letters to the CSOs were written by CSF, and informative sharing courtesy calls were made to the respective district authorities. Informed consent was obtained from all the participants prior to participation in the study. We ensured confidentiality for all study participants by conducting interviews in places with adequate privacy and not using participant names for data analysis. We also ensured that study participants were issued with a written informed consent detailing the study, the risks and benefits, and emphasis on the protection of confidentiality. Written Consent was obtained for the survey participants and FGDs participants while a verbal consent was obtained for KIIs.

3. RESULTS

This section presents the results from both the quantitative survey and the qualitative methods. Results are presented according to the study objectives that were assessed. The first section shows the characteristics of the households that participated in the study and the responds.

3.1 Characteristics of the sampled households

Table 3.1a shows sampled household characteristics in the Male involvement study. A total of 873 households consented to study participation resulting in a high response rate, 96% (873/909). The average (SD) household size was 5.8 (2.8) and 11% of the household reported at least one orphan aged less than 15 years. Only a third (33%) of the households were classified as having a “high” social economic status defined as a house structure with modern construction materials (*Roof: Iron/tile, Floor: Cement/wood and Walls: Cement/bricks*), while half (50%) of households were of low SES) Toilet coverage was 91% implying that 1 in 10 households could be at increased risk of poor faecal disposal health problems such as diarrhea and cholera. Electricity was only in 17% of the households. Just about three quarters (75%) had access to communication (radios), and 57% had bicycles.

Table 3.1a Household Characteristics

Total	Number 873	Percentage, % 100
Household size		
Mean (SD)	5.8(2.8)	
Household with under 15 year children	312	35.7
Children aged less than 15years		
Mean (SD) number	2.9 (2.0)	
Household with orphans aged < 15 year	93	10.7
*Social Economic Status (SES)		
Based on house construction materials		
High	279	33.0
Medium	145	17.2
Low	421	49.8
Possession of;		
Toilet (n=866)	786	90.8
Power (electricity, n=864)	147	17.0
Mobile Phone (n=863)	620	71.8
Radio (n=866)	656	75.8
Bicycle (n=865)	490	56.7
Motorcar (n=854)	17	2.0
Lorry (n=853)	6	0.70

***SES: High=Roof: Iron/tile Floor: Cement/wood Walls: Cement/bricks; Medium=at most 2 of items in High; Low=at most one item in high**

Table 3.1b shows household characteristics by regions. By design, the number of households varied by regions; Central (24%) and the Eastern (23%) regions provided the highest respondents, while West Nile (5.7%) had the least. The mean (SD) household size was highest in the Eastern region 7.2 (2.89) and lowest in both Central 4.1 (2.18) and South-West, 4.5 (2.13). Also the mean (SD) number of under-15 year children was highest in the Eastern 3.7 (2.00), and lowest in the Central 1.9(1.68). The Northern and Eastern regions had the highest household prevalence of orphan hood, (17%), while none of the households in Western region reported any orphan. Majority of the households in West-Nile were of low SES, 82% compared to only 12% in Central region. Possession of Mobile phones was common (>60%) in all regions except West-Nile where only 29% of the households had at least one mobile phone. In all regions, except for the Central (40%) and Western (35%) regions, majority of the households in all other regions did not have electricity supply. Social economic status (SES) was widely variable by study regions. About a third (66%) of the households in Central region were classified as High SES, compared to 42% in Mid-Western, and 30.3% in Western regions. Only 4% of the surveyed households in West-Nile region were High SES. Regional differences in SES were statistical significant.

Table 3.1b Household characteristics by Region

	Central		East-Central		Eastern		Mid-Western		North		South-West		West-Nile	
	Kampala, Masaka Mityana		Kamuli, Iganga		Busia, Soroti, Bukedea		Hoima, Masindi		Lira, Oyam		Kabale, Mbarara		Arua	
Characteristics	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Households visited	209		94		199		124		100		97		50	
Average (SD) size	4.1	(2.18)	6.2	(2.95)	7.2	(2.89)	6.2	(2.99)	6.0	(2.36)	4.5	(2.13)	6.7	(2.23)
Mean(SD) number of under-15 yr children	1.9	(1.68)	3.2	(2.17)	3.7	(2.00)	3.0	(2.02)	3.3	(1.84)	2.1	(1.80)	3.3	(1.84)
Households with children, aged 0-14 years	32	15.3	37	39.4	104	52.3	46	37.1	45	45.0	25	25.8	23	46.0
HHs with orphans, aged 0-14 years	23	11.0	9	9.6	33	16.6	9	7.3	17	17.0	0	0.0	2	4.0
<i>*Social economic status</i>														
House construction materials														
High		66.2		22.8		14.4		30.3		17.7		41.5		4.1
Medium		21.7		45.7		5.9		16.8		8.3		12.8		14.3
Low		12.1		31.5		79.8		52.9		74.0		45.7		81.6
Possessions														
Toilet		98.6		92.6		79.6		99.2		84.8		98.9		74.0
Power (electricity)		39.7		2.1		0.5		13.8		4.1		34.7		14.0
Mobile Phone		79.8		60.6		71.9		80.5		66.3		82.1		28.6

**SES: High=Roof: Iron/tile Floor: Cement/wood Walls: Cement/bricks; Medium=at most 2 of items in High; Low=at most one item in high*

Sex and age distribution of household members in selected villages are presented in Tables 3.1c and Table 3.3 by study regions. Age distribution was comparable by male and female household members (Table 3.2). About half of the population was aged below 15 years and 40% were in the study age eligibility (18-49 years for females) and (18-54 years for males). Variability by region in age and sex distribution is shown in Table 3.3. Overall the proportion of females was lower than males in the three regions of East-Central (47%), East (48%) and Northern (49%). However, a higher proportion of young (0-14 years) females compared to males was only observed in the East-Central region, 55% versus 50%, respectively.

Table 3.2 Sex and age distribution of all study household members

	Number	Percentage, %
Sex		
Female	2,477	49.3
Male	2,547	50.7
Male-age (years)		
0-14	1,292	50.7
15-17	165	6.5
18-54	1,017	39.9
54+	73	2.9
Female-age(years)		
0-14	1,208	48.8
15-17	151	6.1
18-49	1,045	42.2
50+	73	3.0

Table 3.3 Sex and age distribution of all study household members by region

	Central		East-Central		Eastern		Mid-Western		North		South-West		West-Nile	
	Kampala, Masaka, Mityana		Kamuli, Iganga		Busia, Soroti, Bukedea		Hoima, Masindi		Lira, Oyam		Kabale, Mbarara		Arua	
Characteristics	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Sex	861	100.0	582	100.0	1,439	100.0	769	100.0	603	100.0	437	100.0	333	100.0
Female	432	50.2	273	46.9	692	48.1	392	51.0	294	48.8	220	50.3	167	50.2
Male	429	49.8	309	53.1	747	51.9	377	49.0	309	51.2	217	49.7	166	49.8
Female-age(years)	432	100.0	273	100.0	692	100.0	392	100.0	294	100.0	220	100.0	167	100.0
0-14	188	43.5	150	54.9	344	49.7	190	48.5	157	53.4	100	45.5	78	46.7
15-17	15	3.5	13	4.8	47	6.8	31	7.9	22	7.5	11	5.0	11	6.6
18-49	214	49.5	100	36.6	284	41.0	156	39.8	109	37.1	108	49.1	68	40.7
50+	15	3.5	10	3.7	17	2.5	15	3.8	6	2.0	1	0.5	10	6.0
Male-age(years)	429	100.0	309	100.0	747	100.0	377	100.0	309	100.0	217	100.0	166	100.0
0-14	207	48.3	155	50.2	386	51.7	186	49.3	174	56.3	100	46.1	87	52.4
15-17	27	6.3	24	7.8	49	6.6	28	7.4	27	8.7	4	1.8	8	4.8
18-54	184	42.9	122	39.5	299	40.0	149	39.5	98	31.7	107	49.3	60	36.1
54+	11	2.6	8	2.6	13	1.7	14	3.7	10	3.2	6	2.8	11	6.6

3.2: Characteristics of study respondents

Table 3.3 shows study respondent characteristics. By design, Central (Masaka, Mityana and Kampala districts) (24%) and the Eastern (Busia, Soroti and Bukedea districts) (23%) regions provided the highest respondents, while West Nile (Arua) (6%) had the least based on the number of CSOs operating in their regions and districts. Just over a quarter of the respondents were male (27%) or aged 18-24 years (27%). About three quarters of the respondents (77%) were engaged in non-cash occupations mainly agriculture, students and home-chores. Only 5% were engaged in cash-related occupations considered to be “white collar jobs” such as government workers, health workers and security; while the rest were involved in “Blue-collar jobs” including fishing, vending and bars attendants. Only a third (32.8%) had attained post-primary education, although majority of respondents were of primary level of education (58%). Three quarters were currently married (75%), and 17% of the married were in polygamous marital unions. Non-marital relationships were also common, 18%. Anglican (42.8%) was the commonest faith, but the proportion of Muslims (11%) and Pentecostal/Seventh day Adventists (10%) was similar.

Table 3.3 Study respondents characteristics

Total	Number, n 873	Percentage, % 100.0
Study region		
Central	209	23.9
East Central	94	10.8
Eastern	199	22.8
Mid-Western	124	14.2
North	100	11.5
South West	97	11.1
West Nile	50	5.7
Respondent's sex		
Female	636	72.9
Male	237	27.2
Age (years)		
18-24	238	27.4
25-39	487	56.1
40-54	143	16.5
Primary occupation		
Agriculture/home/student	670	77.3
Blue-collar (e.g. Bar, vending)	152	17.5
White collar (e.g. Government/H-worker)	45	5.2
Schooling/Education		
Never at School	78	8.9
Primary	509	58.3
Post-primary	286	32.8
Current marital status		
Never married	108	12.4
Currently married	655	75.0
Divorced/Separated/Widowed	110	12.6
Type of marital union		
Not currently married	218	25.4
Monogamy	530	61.8
Polygamy (2 or more spouses)	110	12.8
None marital relationships		
No	709	81.6
Yes	160	18.4
Religion		
Catholic	313	35.9
Anglican	373	42.8
Muslim	97	11.1
Pentecostal /SDA	89	10.2

3.2.1 Sexual and reproductive health characteristics

Table 3.4 shows a total of 864 respondents (635 females and 229 males) with data on the key sexual and reproductive health characteristics.

Sexual activity

Overall, almost all respondents reported to have ever had sexual intercourse, significantly higher among females, 98.4% compared to males, 94%, $p=0.0009$. However, a significantly higher proportion of sexually active men reported to have had sex in the past 12 months prior to the survey, 93% compared to females, 84% $p=0.0009$. On average, sexually active women reported 1.2 (SD=1.03) sexual partners in the past 12 month relative to 1.5(SD=1.05) among male respondents, $p<0.001$. The reported rate of current pregnancy was 12%, and this did not differ by men's report of their spouse's pregnancy status (12%) or by female's own self-report (12%).

Desire for a (another) child

Among the 85 respondents who reported either being currently pregnant or their spouses being current pregnant, about 46% wanted to delay another child for more than 2-years, while 44% wanted to limit childbearing. These fertility desires among the currently pregnant did not differ by either female self-reports or male's report of their spouses. About 11% of the currently pregnant women or spouses of the pregnant women report that they tried terminating the current pregnancy; this may suggest the prevalence of unwanted pregnancies.

Among the current non-pregnant women or spouses who reported non-pregnant partners, about a quarter, 26% wanted to postpone childbearing by more than 2-years, while close to half (48%) wanted to stop childbearing. Stopping childbearing tended to be higher among female respondents, 50% compared to male respondents, 42% $p=0.0791$. However, a significantly lower proportion of females (10%) wanted a delay of less than 1 year or were undecided compared to 17% of the male respondents, $p=0.0121$.

Table 3.4: Sexual and reproductive health characteristics of respondents

	Female Number, n	%	Male Number, n	%	Total Number, n	%
Total	635	100	229	100	864	100
Characteristics						
Ever had sex						
Never had	10	1.6	13	5.7	23	2.7
Yes ever had	625	98.4	216	94.3	841	97.3
Sex in past 12m	625	100	216	100	839	100
No	100	16.1	15	7.0	115	14.7
Yes	523	83.9	199	93.0	722	86.3
Sexual partners 12m						
Mean (SD)	1.2(1.03)		1.5 (1.05)		1.2 (1.04)	
Fertility						
Reported Pregnancy	611	100.0	180	100.0	791	100.0
Never been pregnant	135	22.1	48	26.7	183	23.1
Currently pregnant	71	11.6	22	12.2	93	11.8
Ever, but not current	405	66.3	110	61.1	515	65.1
Desire a (another) child						
Currently pregnant	64	100.0	21	100.0	85	100.0
Need no more children	27	42.2	10	47.6	37	43.5
More than 2-year delay	30	46.9	9	42.9	39	45.9
1-2 years delay/undecided	7	10.9	2	9.5	9	10.6
Terminate current pregnancy						
No, did not try	57	87.7	20	95.2	77	89.5
Yes, tried	8	12.3	1	4.8	9	10.5
Currently Not pregnant	517	100.0	153	100.0	670	100.0
Need no more children	258	49.9	64	41.8	322	48.1
More than 2-year delay	137	26.5	34	22.2	171	25.5
1-2 years delay	72	13.9	29	19.0	101	15.1
<1 year delay/undecided	50	9.7	26	17.0	76	11.3

3.3 Current FP use and Male involvement in FP

3.3.1 Use of Family planning Methods

About a third (31%) of the currently pregnant women was using a FP method prior to becoming pregnant. The most common FP methods among those with unplanned pregnancies were hormonal contraceptives (67%; especially injectables 48%) followed by none modern methods (22%; herbal and breast-feeding).

Among the non pregnant female respondents or males whose spouses were not pregnant, FP use was high, 49%. A significantly higher proportion of male respondents reported FP use 60% compared to 46% of female respondents, $p = 0.0025$. The most commonly mentioned FP methods

was hormonal contraceptives, 64%; reported more by female respondents 68% compared to 51% among male respondents, $p=0.0324$. However, use of male condoms was more significantly mentioned by male respondents, 32% compared to 8% among females. Tubal ligation was more commonly reported by females, 7% relative to their male counter parts, 2%.

From the qualitative results, the most commonly used methods of FP reported by FGD participants were condoms (14/16) followed by natural methods of FP (10/16). However, the main reasons for using condoms were for their dual role of both FP and to avoid HIV infection as the men had extra marital affairs. For natural methods, the reason for their popularity was that they do not have side effects.

When I go outside the marriage, I use them to protect me against HIV and STIs, but when I am with my wife, I use them with the view of the number of children I have. FGD, Males 18-24, Iganga

3.3.2 Level of Male-involvement in FP with the last sexual partner

Male involvement in FP with the last sexual partner was assessed as a composite measure with both actual male method use (male condom) and support to the female partner FP use. Using this measure with last partner among non-pregnant respondents or non-pregnant partners at the last sexual encounter, male involvement in FP through use of male FP methods only was only 13%. Use of male methods only was most significantly reported by male respondents, 27% compared to only 8% of the female respondents. When discussion about FP method was included to form a composite measure the level of male involvement was 45%, higher among male respondents 56% relative to female respondents' reports 41% (Table 3.5a). Use of female controlled FP methods without male partner discussion was 17%, but more commonly reported by females, 18% relative to male reports, 14%. Conversely, male-involvement tended to be more significantly reported by male respondents partly because of the differentials in reported male condom use.

Overall, 53% of the respondents reported use of any FP method at the last sexual encounter, significantly higher among male respondents, 61% compared to 50% female respondents, $p=0.0154$. The most commonly reported FP methods were hormonal (injections/pills)/IUDs, 32% followed by male condoms reported by 27% of the male and only 7% of the female respondents. Use of traditional methods (herbs/calendar/breast-feeding) was reported by 6%, while tubal ligation was reported by 3%. Females were more likely to bring the FP method to the sexual relations, 93% compared to 77% of the males. The most common sources of FP methods were government health

facilities (51%), followed by private health facilities (19%) and drug shops (11%). Only 3% were reported as coming from outreach services/providers.

The prevalence of pregnancy at last sexual encounter was 17%, and was consistently reported by both the female and male respondents. Desire for more children was high, 41% based on a composite measure of reporting a desire for another child or being pregnant at the time of last sexual encounter (32% desired more irrespective of their pregnancy status at last sexual encounter while 5% responded as being pregnant at last sex encounter without explicitly stating their desire for another child). Female's desire for more children (37%) was higher than the reported male's desire (34%) during the last sexual encounter. Whether sexual partner is marital or non-marital may determine male-involvement in FP use. The prevalence of non-marital sexual encounters at last sex was significantly higher among male respondents, 28% relative to the females 14%. Also a third (32%) of males reported older sexual partners at the last sexual encounter compared to 4.8% females who reported younger partners.

Table 3.5a: Male involvement in FP and Family planning use during last sexual partner

	Female Number, n	%	Male Number, n	%	Total Number, n	%
Male Involvement in FP use						
<i>Discussion not included</i>	453	100.0	162	100.0	615	100.0
Not using any FP	234	51.7	63	38.9	297	48.3
Male method mentioned	34	7.5	44	27.2	78	12.7
Only female-method	185	40.8	55	34.0	240	39.0
<i>Discussion included</i>	450	100.0	160	100.0	610	100.0
Not using any FP	182	40.4	47	29.4	229	37.5
Male method/FP discussion	186	41.3	90	56.3	276	45.2
Only female-method	82	18.2	23	14.4	105	17.2
Use of any FP at last sex	470	100.0	164	100.0	634	100.0
No	234	49.8	63	38.4	297	46.8
Yes	236	50.2	101	61.6	337	53.2
FP method last sex						
No FP used	234	49.9	63	38.4	297	46.9
Traditional	28	6.0	10	6.1	38	6.0
Male-condom	34	7.2	44	26.8	78	12.3
Hormonal	157	33.5	45	27.4	202	31.9
Tubal ligation	16	3.4	2	1.2	18	2.8
Who brought FP method?	230	100.0	100	100.0	330	100.0
Respond-brought	213	92.6	76	76.0	289	87.6
Partner-brought	17	7.4	24	24.0	41	12.4
Source of FP used at last sex	227	100.0	100	100.0	327	100.0
Government health facility	113	49.8	53	53.0	166	50.8
Private health facility	46	20.3	17	17.0	63	19.3
Drug shop	21	9.3	15	15.0	36	11.0
Pharmacy	20	8.8	2	2.0	22	6.7
Outreach services/ provider	7	3.1	2	2.0	9	2.8
Other specify	18	7.9	9	9.0	27	8.3
Don't know	2	0.9	2	2.0	4	1.2
Desire for a (another) child (including currently pregnant)	503	100.0	192	100.0	695	100.0
No	266	52.9	112	58.3	378	54.4
Yes, need More	172	34.2	50	26.0	222	31.9
Don't know	49	9.7	15	7.8	64	9.2
Pregnant at last sex	16	3.2	15	7.8	31	4.5
Pregnancy status, last sex	505	100.0	188	100.0	693	100.0
Not	416	82.4	153	81.4	569	82.1
Yes	89	17.6	35	18.6	124	17.9
Desire for a (another) child (includes only non-pregnant)	470	100.0	169	100.0	639	100.0
No	269	57.2	113	66.9	382	59.8
Yes, need More	153	32.6	39	23.1	192	30.0
Don't know	48	10.2	17	10.1	65	10.2

Table 3.5b: Male involvement with the last sexual partner, desire for child bearing and unmet need for Family planning by survey regions

	Central		East-Central		Eastern		Mid-Western		North		South-West		West-Nile	
	Kampala, Masaka/Mityana		Kamuli, Iganga		Busia, Soroti, Bukedea		Hoima, Masindi		Lira, Oyam		Kabale, Mbarara		Arua	
Characteristics	N	%	n	%	n	%	n	%	n	%	n	%	n	%
Male mean (SD) age	31.8	(9.3)	29.4	(11.2)	33.7	(8.9)	32.5	(8.3)	28.2	(9.6)	35.7	(12.7)	30.8	(6.9)
Female mean (SD) age	29.1	(9.5)	32.9	(14.0)	30.3	(9.5)	31.8	(8.4)	31.6	(7.9)	29.1	(6.8)	28.9	(8.5)
Male Involvement in FP use (Last sexual partner)	149	100.0	52	100.0	128	100.0	96	100.0	72	100.0	79	100.0	34	100.0
Not using any FP	53	35.6	22	42.3	40	31.3	40	41.7	24	33.3	27	34.2	23	67.6
Male method/FP discussion	68	45.6	26	50.0	72	56.3	39	40.6	27	37.5	33	41.8	11	32.4
Only female-method (Last sexual partner)	28	18.8	4	7.7	16	12.5	17	17.7	21	29.2	19	24.1	0	0.0
Not using any FP/Only female	81	54.4	26	50.0	56	43.8	57	59.4	45	62.5	46	58.2	23	67.6
Male method/FP discussion	68	45.6	26	50.0	72	56.3	39	40.6	27	37.5	33	41.8	11	32.4
Unmet need for FP (Last sexual partner)	94	100.0	40	100.0	95	100.0	64	100.0	70	100.0	43	100.0	29	100.0
No, do not have	64	68.1	26	65.0	65	68.4	35	54.7	49	70.0	32	74.4	13	44.8
Yes, have	30	31.9	14	35.0	30	31.6	29	45.3	21	30.0	11	25.6	16	55.2
Child desire (Last sexual partner)	154	100.0	50	100.0	127	100.0	96	100.0	68	100.0	79	100.0	33	100.0
Need no more children	87	56.5	27	54.0	79	62.2	56	58.3	58	85.3	36	45.6	20	60.6
Need more	54	35.1	15	30.0	29	22.8	33	34.4	9	13.2	32	40.5	9	27.3
Do not know	13	8.4	8	16.0	19	15.0	7	7.3	1	1.5	11	13.9	4	12.1

Male involvement varied considerably by study regions; Eastern (56%) and East-central (50%) had the at least half reporting male-involvement while only a third (32%) were involved in West-Nile and 37.5% in the North.(Table 3.5b) Eastern region with the highest level of male-involvement also had the lowest unmet need for FP, while West-Nile at 32% male-involvement had the highest unmet need for FP (55%).

3.3.3 Male involvement with all partners

Further, male involvement was assessed generally without specifically focusing on the last sexual partner. This indicator is likely to yield a higher level of male involvement than with the last sexual partner because it could be that the respondent remembers use with one of the partners who may not be the most recent. Also, a measure which does not focus on specific sexual partner relationship tends to provide “average” responses for the multiple relationships one had sex with thus creating a potential over or under estimate. When male involvement is defined as use of male methods with the partner(s), the overall rate was 10%. This was also significantly higher among male respondents, 22% compared to only 7% female respondents just like it was with the most recent sexual partner. When the definition is expanded to include discussion of FP method with the male partner, or the decision to use the current FP method includes the male partner (either by male alone or joint), the overall prevalence of male involvement increases to 36%. Male involvement by this later definition is also more significantly reported by male, 54% compared to females, 31%. This increase from the male method alone of 10% suggests that the male partner is engaged in the decision and discussion to use the current FP methods, including those that are female controlled. However, the 16% FP use as mentioned by females without the decision/discussion with the male partner still indicates the level of non-male involvement that may need to be addressed.

Table 3.6: FP use and male involvement in FP

	Female Number, n	%	Male Number, n	%	Total Number, n	%
Among current pregnant/males reporting currently pregnant partners						
Family planning use						
Before current pregnancy	65	100	22	100	87	100
No, was not using	42	64.6	18	81.8	60	69.0
Yes, was using	23	35.4	4	18.2	27	31.0
<i>FP just before pregnancy (among users)</i>	23	100	4	100	27	100
Pill	3	13.0	1	25.0	4	14.8
Male condom	2	8.7	1	25.0	3	11.1
Injection	11	47.8	2	50.0	13	48.1
Breast-feeding	2	8.7			2	7.4
Herbs/traditional medicine	4	17.4			4	14.8
Implants	1	4.3			1	3.7
<i>FP just before pregnancy (Categories/collapsed methods)</i>						
Hormonal (pills/injectables/Implant)	15	65.1	3	75.0	18	66.7
Male condom	2	8.7	1	25.0	3	11.1
None modern (breast-feeding/herbs)	6	13.0	0	-	6	22.2
Among non-pregnant/males reporting non-pregnant partners						
None currently pregnant	537	100	157	100	694	100
No, not using any FP	289	53.8	63	40.1	352	50.7
Yes, using FP	248	46.2	94	59.9	342	49.3
<i>FP method currently used</i>	246	100.0	94	100.0	340	100.0
None modern/Traditional	41	16.7	14	14.9	55	16.2
Hormonal/Coil	168	68.3	48	51.1	216	63.5
Male condom-only	19	7.7	30	31.9	49	14.4
Tubal ligation/Vasectomy	18	7.3	2	2.1	20	5.9
Male Involvement in FP use	535	100.0	157	100.0	692	100.0
<i>Discussion not included</i>						
Not using any FP	289	54.0	63	40.1	352	50.9
Male_method mentioned	35	6.5	35	22.3	70	10.1
Only female-method	211	39.4	59	37.6	270	39.0
<i>Discussion included</i>						
Not using any FP	289	54.0	63	40.1	352	50.9
Male_method/FP discussion	163	30.5	84	53.5	247	35.7
Only female-method	83	15.5	10	6.4	93	13.4

The level of male involvement in FP assessed using qualitative interviews

Qualitative data from FGDs revealed that the level of male involvement in FP was relatively low. This is in line with the quantitative survey results above. A number of reasons for low involvement were that – there was no sensitisation focusing on men about FP, fear of side effects there by leading to low use. Another commonly reported reason for low involvement of males in FP was that FP activities tend to focus on the females and the range of methods is mainly female controlled. In addition, the men as heads of households are preoccupied with economic welfare and therefore un-able to have time to accompany their partners for FP services.

The reason why fewer men take part in FP is that, they don't get enough sensitization about FP. In most cases, it is the women who are sensitized and the men are left out. Even on the radio the announcements are directed to the women. Men are not called, so most of us feel the women can finish this. FGD Males, 18-24, Lira

The problem is that women grow very fat. In my case I sweet talked my wife to stop using FP when I wanted her to give birth. Then she became pregnant but I was scared I would have a child without limbs, but God helped us. After giving birth, she resumed FP but got complications as she bled for over 3 months. FGD Males, 18-24, Iganga

Nearly half of the FGDs pointed out that the men wanted many children for social security, cultural reasons mainly.

In our community in the central region (Buganda), there is talk that we should have more children. This is especially common over some radio stations, you can hear them urging people to give birth to many children 'omusajja tagererwa nzaalo' (you can't limit the number of children for a man). So in our community here in Buganda you find that the men are not involved in FP, it is regarded to be natural for the men to have so many children. FGD Males, 25 and above, Masaka

3.4 Factors associated with Male Involvement

Table 3.7 shows the unadjusted and adjusted relative risk ratios of male-involvement by respondent characteristics, perceptions, beliefs and attitudes about family planning among non-pregnant participants or male partners of non-pregnant women. A total of 635 participants had complete data available for this analysis. The RRR from the multinomial logistic regression are interpreted as odds ratios in this analysis. A borderline significant intra- study regional variation in male-involvement in FP was observed ($\rho=0.020$ (0.0025, 0.1487); $p=0.057$) using a logistic regression random effects model with no covariates. A statistical significant intra-study community variation in male-involvement in FP $\rho=0.10$ (0.0432, 0.2161) $p<0.001$. Also a significant regional variability in FP use was observed in a similar model, ($\rho=0.086$ (0.0233,0.270); $p<0.001$). Therefore, clustering of observations at the village level was adjusted for in the multinomial logistic regression model to determine factors associated with male-involvement in FP. Factors significantly associated with higher odds of male-involvement in FP were non-marital relationships, adj.RRR=1.94 (1.43, 3.32); having had talks about FP, adj.RRR=2.72 (1.71, 4.33); being aware of HIV care services in the community, adj.RRR=1.42 (0.95, 2.12) and perceiving use of HAART as either having a decreasing, adj.RRR=2.59 (1.18,5.70) or an increasing adj.RRR=2.75 (1.37,5.50) effect on Males tended to report male-involvement relative to female respondents, adj.RRR=2.52(1.44,4.39). Although Post-primary level of educations, adj.RRR=2.05 (0.85,4.94), being currently marriage (irrespective of type of marriage, monogamous or polygamous) and possession of mobile phone or radio did not reach a 5% statistical level of association, their relative risk ratios (RRR) were substantially elevated suggesting a potential association with male-involvement. Factors significantly associated with lower odds of male-involvement included being divorced/separated/widowed, adj.RRR=0.26 (0.10, 0.73) compared to never married, large family size (6+ co-resident children aged less than 15 years) compared to smaller family sizes (2 or fewer co-resident under 15 year old children) and low social economic status, adj.RRR=0.56 (0.32, 0.98). A surprising result was reduced odds of male-involvement for FP among respondents in white collar jobs, adj.RRR=0.44 (0.20, 0.97) relative to those in agriculture/home chores or students. Religion was also observed to be a potential barrier to male-involvement for FP, Pentecostals/SDA compared to Catholics, adj.RRR=0.53 (0.27,1.06). In the bivariate analysis, perceptions, attitudes and beliefs about FP were important determinants of male-involvement. Participants who disagreed to the statement that “*couple counseling can improve male involvement*” were 60% less likely to report male-involvement compared to those who agreed; this was also observed among participants

who disagreed that “FP benefits males too” adj.RRR= 0.41 (0.19, 0.88) compared to those who agreed. This result may suggest that FP may still be perceived as being beneficial to the females mainly, and not the men. However, this observation was inconsistent with a result showing that male-involvement was significantly increased when participants disagreed to the statement that FP is for females only and not men. Those not sure whether (neutral) “FP is acceptable or who disagreed about FP being acceptable in their community” were less likely to report male involvement adj.RRR=0.51 (0.30, 0.87).

Table 3.7: The unadjusted and adjusted Relative Risk Ratios (RRR) of Male-Involvement by characteristics, perceptions belief and attitudes of FP among non-pregnant participants or those with non-pregnant spouses/partners

	Male-involve vs No FP		Female method-only vs No FP	
	Unadjusted (95% CI)	Adj.RRR (95% CI)	Unadjusted (95% CI)	Adj.RRR (95% CI)
Characteristics				
Social-demographics				
Sex				
Female	1.0	1.0	1.0	1.0
Male	2.32(1.45,3.71)	2.52 (1.44, 4.39)	0.57 (0.30,1.07)	0.51 (0.24, 1.08)
Age category (years)				
18-24	1.0	1.0	1.0	1.0
25-39	1.11 (0.76, 1.64)	1.09 (0.71, 1.65)	1.66 (0.95, 2.89)	1.37 (0.70, 2.67)
40-54	0.79 (0.44, 1.40)	0.86(0.43, 1.69)	1.07 (0.61, 1.88)	0.96(0.47, 1.99)
Marital status				
Not married	1.0		1.0	
Currently married	0.96 (0.54, 1.70)		3.66 (1.18, 11.35)	
Divorced/separated/widowed	0.21 (0.09, 0.46)		2.41 (0.62, 9.43)	
Marital Type				
Not married	1.0	1.0	1.0	
Divorced/separated/widowed	0.21 (0.09, 0.46)	0.26(0.10, 0.73)	2.41 (0.62, 9.43)	2.38(0.48,11.73)
Monogamy	0.98 (0.55, 1.75)	1.68(0.68, 4.13)	2.96 (0.89, 9.84)	3.95 (0.96, 16.20)
Polygamy	0.84 (0.41, 1.69)	1.68 (0.65, 4.35)	7.18 (2.35, 21.90)	8.63(2.28, 32.67)
Non-marital relationships				
None	1.0	1.0	1.0	1.0
Yes, have	1.51 (1.02, 2.23)	1.94 (1.14, 3.32)	1.09 (0.61, 1.96)	1.90 (0.96, 3.75)
Faith/Religion				
Catholic	1.0	1.0	1.0	1.0
Anglican	0.87 (0.55, 1.38)	0.75(0.45, 1.25)	0.96 (0.56, 1.63)	1.03(0.58, 1.84)
Muslim	0.67 (0.33, 1.38)	0.83(0.45,1.55)	0.96 (0.38, 2.38)	0.76(0.35, 1.68)
Pentecostal /SDA	0.59 (0.36, 0.97)	0.53(0.27, 1.06)	0.89 (0.41, 1.95)	0.84(0.37, 1.91)
Number of U-15 year olds in household				
0-2	1.0	1.0	1.0	1.0
3-5	1.20 (0.88, 1.64)	1.28(0.88, 1.87)	1.14 (0.65, 1.98)	1.30 (0.75, 2.24)
6+	0.71 (0.40, 1.26)	0.48(0.25, 0.95)	0.80 (0.40, 1.58)	0.94(0.43, 2.08)
Highest education level				
Never at School	1.0	1.0	1.0	1.0
Primary	1.82 (0.92, 3.60)	1.70 (0.75, 3.87)	1.23 (0.60, 2.53)	1.15(0.55, 2.42)
Post-primary	2.45 (1.21, 4.97)	2.05(0.85, 4.94)	1.13 (0.46, 2.74)	1.00 (0.38, 2.64)
Main occupation				
Agriculture/home/student	1.0	1.0	1.0	1.0
Blue-collar	1.22 (0.73, 2.05)	0.88(0.50, 1.55)	2.16 (1.32, 3.51)	2.45(1.52,3.97)
White collar govt/Health worker	0.74 (0.33, 1.65)	0.44(0.20, 0.97)	0.42 (0.08, 2.38)	0.43(0.07,2.5)

	Male-involve vs No FP		Female method-only vs No FP	
	Unadjusted (95% CI)	Adj.RRR (95% CI)	Unadjusted (95% CI)	Adj.RRR (95% CI)
Wealth/SES (Possessions)				
Mobile Phone	1.80 (1.20, 2.68)	1.30(0.74, 2.27)	1.93 (1.08, 3.45)	1.77(0.92,3.42)
Radios	1.83 (1.18, 2.85)	1.21(0.73, 2.02)	0.98 (0.57, 1.67)	0.76(0.42, 1.37)
Bicycle	1.25 (0.87, 1.79)		0.75 (0.47, 1.19)	
Toilet	1.95 (1.02, 3.72)		1.65 (0.62, 4.37)	
Electricity	1.18 (0.62, 2.28)		1.86 (0.85, 4.04)	
Building/Construction material				
Highest	1.0	1.0	1.0	1.0
Middle	0.81 (0.44, 1.49)	1.01(0.53,1.92)	0.47 (0.22, 0.99)	0.56(0.24, 1.31)
Lowest	0.76 (0.45, 1.28)	0.56(0.32,0.98)	0.52 (0.25, 1.05)	0.64(0.30, 1.34)
HIV care/FP services				
Effect of HAART on FP use				
No effect	1.0	1.0	1.0	1.0
Decreased	1.86 (0.93, 3.69)	2.59(1.18, 5.70)	1.57 (0.69, 3.56)	1.61(0.71,3.67)
Increased	2.23 (1.38, 3.62)	2.75(1.37, 5.50)	0.96 (0.48, 1.94)	0.76(0.38,1.51)
Do not know	0.92 (0.46, 1.83)	1.38(0.64,2.96)	0.57 (0.29, 1.14)	0.58(0.30, 1.15)
Talked to you about FP (yes)	2.42 (1.59, 3.67)	2.72(1.71,4.33)	1.16 (0.722, 1.87)	1.25(0.73,2.13)
Aware of HIV care services in community				
	1.78 (1.23, 2.57)	1.42(0.95, 2.12)	0.96 (0.58, 1.61)	1.01 (0.59, 1.75)
Perceptions/attitudes/Beliefs				
Couple counselling can improve male involve				
Agree	1.0		1.0	
Neutral	0.32 (0.14, 0.75)		1.75 (0.73, 4.21)	
Disagree	0.41 (0.17, 0.98)		0.92 (0.42, 2.01)	
FP for females-only not men				
Agree	1.0		1.0	
Neutral	0.27 (0.05, 1.37)		1.45 (0.48, 4.37)	
Disagree	1.85 (1.21, 2.82)		1.04 (0.62, 1.77)	
FP is acceptable in my community				
Agree	1.0		1.0	
Neutral	0.51 (0.30, 0.87)		0.63 (0.32, 1.25)	
Disagree	0.43 (0.18, 1.05)		0.70 (0.30, 1.65)	
FP benefits males too				
Agree	1.0		1.0	
Neutral	0.17 (0.05, 0.57)		0.81 (0.33, 2.02)	
Disagree	0.41 (0.19, 0.88)		0.76 (0.33, 1.76)	

3.5 Knowledge of men and women towards FP methods

From the qualitative interviews conducted, FP was understood by nearly all the FGDs to mean limiting number of children and child spacing. Participants further clarified that FP is instrumental for planning for the children in terms of welfare and securing their future.

Several FP methods were mentioned by the FGD participants. Specifically these included hormonal, barrier, natural, permanent and folk methods. It is important to note that all FGD (male + female) of all age categories knew hormonal methods such as oral contraceptive pill, injectables (depo provera) and implants. Knowledge of hormonal methods was well distributed within by gender, regions and age. However comprehensive knowledge was not assessed.

The first FP method that I know is; the women use injectables. They no longer like pills so much because they cause fibroids. For me as a man, the FP method I trust is that when my wife has just completed her monthly periods, I spend 14 days to (laughter) that is my traditional method, I take 14 days then I kick the ball again (and then I have sex with her again). For me that is what I use. (FGD, Males 25 and above, Masaka).

There is also one which they put in your uterus. They tell you to lie down and then it is inserted inside you. FGD females, 25 and above, Lira

Nearly all FGDs (14/16) highlighted male condoms as a barrier method of FP. Nearly two thirds of the FGDs knew natural FP methods in the community. The commonly mentioned natural methods were withdrawal, periodic abstinence and rhythm.

There are some couples who when they reach their menstruation periods count the days together and in this way they can prevent pregnancies and space their children.

Slightly over half of the FGDs knew permanent methods of FP i.e. tubaligation and Vasectomy for the males. It ought to be noted that for females there was no mention of permanent methods in Masaka district.

There is that one where your tubes are cut and this is permanent and you can never have any children again. FGD females, 25 and above, Lira

I have ever heard about vasectomy but I am not sure if anyone has ever done it. FGD Males, 25 and above, Lira

Half of the FGDs knew about folk methods (use of herbs, blood). Interestingly, in spite of the male methods being limited, nearly all the male FGDs knew some folk methods of FP.

Here, some women use their blood during the first menstruation after birth. They put menstruation blood mixed with herbs in a piece of cloth, tied and hanged up in the Kitchen. In case one wants to have another child, then they untie the cloth. FGD, Males 18-24, Iganga

3.6 Attitudes and beliefs towards the various modern FP methods and male involvement in FP

3.6.1 Male attitudes and beliefs towards FP

Both male and female FGDs discussed male views about FP methods. All the FGDs indicated that males had negative views about FP methods.

Both male and female FGDs overwhelmingly mentioned FP side effects.

Some have left their marriages. When one goes to clinic to have an injection secretly and begin to have side effects, the men tell them “that is what you wanted to do and I did not tell you to do that, okay now leave my house”. Now that becomes a problem in that our marriages are destroyed because of using FP methods. We would like to have FP methods so that we can also take care of ourselves but you find the men do not like it. FGD, females 18-24, Mbarara

There are many health issues like high blood pressure which is so common today yet it was not the case previously. We knew that the fat people could get high blood pressure but now even the thin people like me get it because of pills and injectables. Do you see that sir? Injectables also cause dryness. Men got fed up of women who are dry because they get damages during sexual intercourse. FGD, females 25 and above, Masaka

In addition, participants pointed out that contraception promotes promiscuity and that women get opportunity to cheat on their partners since they are certain that they cannot get pregnant.

For me I would advise government to remove FP methods. It has increased prostitution because people now misbehave knowing they will not get pregnant and this has increased on the spread of HIV. Women are now staying with men for many years without giving birth as

they assess your income. It has also caused producing of children with birth defects. FGD, Males 25 and above, Mbarara

People think when one uses FP methods, he will not continue to produce more children. Others think if they start using FP methods, their wives will start cheating on them because they know they will not get pregnant. So men end up saying, 'you will not go there to get the injection, are you the one looking after the children?' FGD, Males 25 and above, Masaka

Issues of methods availability, failure and consistency of use were also raised.

It is important to note particularly that men had negative attitudes towards permanent methods (vasectomy and tubal ligation), therefore decreasing the likelihood of using them. Some of the reasons given by men against vasectomy were that in case a marriage breaks, or a wife dies, it would be difficult to have another wife without a possibility to have children.

For us men we are very difficult, there is no way I would allow vasectomy. We have heard about it but nobody would do it...What if she leaves me and in future I marry another wife who will also want her own children? The women can't accept to raise children when their own are not amongst them. She can't imagine working all day in the garden to feed another woman's child. FGD, Males 25 and above, Lira

But even the women who accept their tubes to be cut are usually those who are sickly and get a lot of complications at delivery but women who are normal would also never accept for their tubes to be cut. FGD, Males 25 and above, Lira

In two thirds of the 16 FGDs it was agreed by consensus that majority of the men are adamant about using any FP methods. They tend to exhibit an “I don’t care attitude” about FP use. However some men also had positive views about FP knowing that it allows families to plan for their children

3.6.2 Perceptions and beliefs towards FP and male involvement

The quantitative survey also elicited perceptions and beliefs about FP and male involvement among the study respondents. The findings of the aforesaid are presented in Table 3.7. A third (34%) of all respondents felt that discussing sexual matters with their partners is not easy. A significantly higher proportion of females relative to male respondent indicated that discussing sexual matters was not easy, 38.5% versus 21.5% $p < 0.001$, respectively. Also the frequency of discussing sexual matters was significantly lower among females, 59% compared to males 76%. This finding is consistent

with the higher level of male-involvement in FP as reported by male respondents compared to female respondents. Majority (86%) of the respondents perceived that couple FP counselling would improve male involvement in FP and this was consistently mentioned by both sexes. About a quarter of the participants, 24% agreed to the statement that “FP is for females only”, irrespective of the sex differences, but 88% agreed that FP benefits males too. Agreement of FP having a community acceptance was high, 78%, although a third (34%) agreed to the statement that FP is for the poor only. FP services were viewed as inaccessible by 41% of the respondents; significantly higher among males 48% compared to the females, 38%, $p=0.0189$.

Table 3.8: Knowledge and Perception about FP and male involvement

	Female Number, n	%	Male Number, n	%	Total Number, n	%
Total	616	100.0	223	100.0	839	100.0
Not easy to discuss sexual matters with partner						
Agree	237	38.5	48	21.5	285	34.0
Agree/disagree	38	6.2	8	3.6	46	5.5
Disagree	341	55.4	167	74.9	508	60.5
Frequently discuss sexual matters with partner	612	100.0	220	100.0	832	100.0
Agree	358	58.5	167	75.9	525	63.1
Agree/disagree	75	12.3	13	5.9	88	10.6
Disagree	179	29.2	40	18.2	219	26.3
Perceptions						
Couple FP counselling improves male involvement						
Agree	623	100.0	227	100.0	850	100.0
Agree	530	85.1	200	88.1	730	85.9
Agree/disagree	49	7.9	9	4.0	58	6.8
Disagree	44	7.1	18	7.9	62	7.3
FP is for females only						
Agree	151	24.2	52	22.7	203	23.8
Agree/disagree	28	4.5	9	3.9	37	4.3
Disagree	444	71.3	168	73.4	612	71.8
FP has community acceptance	626	100.0	225	100.0	851	100.0
Agree	491	78.4	170	75.6	661	77.7
Agree/disagree	97	15.5	37	16.4	134	15.7
Disagree	38	6.1	18	8.0	56	6.6
FP benefits males too	626	100.0	230	100.0	856	100.0
Agree	553	88.3	203	88.3	756	88.3
Agree/disagree	32	5.1	7	3.0	39	4.6
Disagree	41	6.5	20	8.7	61	7.1
FP is for poor only						
Agree	203	32.4	91	39.6	294	34.3
Agree/disagree	26	4.2	5	2.2	31	3.6
Disagree	397	63.4	134	58.3	531	62.0
FP services are inaccessible	622	100.0	227	100.0	849	100.0
Agree	238	38.3	108	47.6	346	40.8
Agree/disagree	56	9.0	20	8.8	76	9.0
Disagree	328	52.7	99	43.6	427	50.3

3.6.3 FP Methods males are willing to use with their partners

To further understand the perceptions of males towards FP and male involvement, the study established the methods that the males felt that could allow their partners to use or use with them. There were two main methods males were willing to allow their partners to use. Three quarters of FGDs mentioned injectables while slightly over half of the FGDs mentioned barrier methods of FP. The main reason given for injectables was that they were long acting while for the barrier methods, the advantage of dual protection was frequently mentioned.

I would recommend the injection because it takes time, I mean once one gets it, you can spend 3 months without any worry, you do everything the way you want it and you don't miss anything. For me I think it would be an easy method. FGD, Males 25 and above, Masaka

The FP methods that I can allow to use are condoms because at times when I have sex with someone who is not my wife it could save me. FGD, Males 25 and above, Lira

It is important to say that men (especially those in the older (category) were willing to allow their spouses use natural FP methods. The reason presented was that they do not have major side effects often common with artificial FP methods. However, in some FGDs it was noted that some natural methods like withdrawal were very hard to use as it would be naturally difficult to withdraw during sexual intercourse.

Men cannot use withdrawal method. ...but even the women can't agree if you try to withdraw, it is almost impossible. Instead of withdrawal you would rather avoid having sex rather than starting then you think you will withdraw. FGD, Males 25 and above, Lira

3.6.4 Decision making for the FP methods to use

Decision making on the methods of FP to use as a couple is also important in male involvement. Perceptions and beliefs that the respondents had towards decision making are presented. The FGD participants discussed decision making responsibilities concerning which methods of FP to adopt. In majority of the FGDs 9/16 it was agreed that the decision should be made jointly (both partners). It is interesting to note that all the male FGDs wished that decisions should be joint with a reason that it affects both partners.

You know what, I just agree with my wife to go for FP since we are best friends. We decided to have FP since we were producing many children and closely spaced yet we have no capacity to look after them. FGD Males, 18-24, Iganga

However, one quarter of the FGDs reported that men should be the ones to make decisions about FP. The reasons given were that men shoulder the financial implications arising from FP use, and also that they are the heads of households.

The man makes the decision like me if I tell the woman that, this method of FP you are using, I don't want you to use it again, the woman will not go back. This is because I make the decisions in the home. FGD Males, 18-24, Lira

3.7 Female partners' perceptions on male involvement in FP and use of male methods

In endeavouring to promote male involvement in FP, it is important to understand what the females think about their partners' involvement. Our results indicate that females were positive about males being involved in FP use in terms of actual use of male methods and decision making on the female methods to use by their partner. The participants in the female FGDs reported that the involvement of men was important to help them share the burden of using contraceptives and to improve on consistent use and compliance for methods of choice. They were also asked which male methods they would prefer their partners to use and the data shows that the most favourable method was the male condom because it has no side effects.

It makes the use of the methods easy for us. For example, when we are in an agreement with our husbands, there is nothing so hard. Now like what my colleague has said the man cannot tear the condom if you both agree to use it..... I also want our husbands to have FP methods like their own pills. This is because I also get tired of always having injections all the time. FGD, females 18-24, Mbarara

Interesting to note is that the women did not like their men to use permanent methods. In fact, the most disfavoured method reported by nearly all the female groups was Vasectomy. This method was perceived by women to make their men sexually dysfunctional; a myth that needs to be corrected.

3.8 Perception of the relevance of FP in HIV prevention

In this study, we also assessed the perceptions of males and females about the relevance of FP specifically FP methods in prevention of HIV infection. Men and women were asked if they knew any methods of FP that could also help prevent HIV infection. They were also asked about their perceptions on these methods. In the qualitative study, all the FGDs reported that the male condoms were a very effective FP method that prevents HIV infection. The other FP method that was highlighted by one third of the FGDs was the abstinence from sexual intercourse. Condoms were viewed as a good FP method because of its dual protection nature i.e. protect individuals from HIV infection as well as prevent possibility for pregnancy.

Condoms are important because some of our children (young women) are with very adulterous men (as partners). It is not about pregnancy only; these condoms can help one relax a bit psychologically because HIV is another issue to fear, leave alone conceiving.
FGD, females 25 and above, Masaka

On the other hand condoms were viewed negatively by majority of the adult female FGDs because several misconceptions regarding condoms still existed. One third of the FGDs pointed out that condom use promoted promiscuity among their partners because they used them for extra marital affairs.

3.9 Attitudes among service providers in providing FP services to the men

This study also assessed service provider attitudes towards provision of services to men. Key informants including managers and actual providers that interface with the clients in FP were included. Majority of healthcare providers felt that it was worth the effort involving men in providing FP services. The main reason presented was that men needed to be part of the entire process of FP.

Yes, it is an excellent idea to involve the men. If I can borrow some quotation from a luganda proverb; 'abayita ababiri bejukanya', (two people can always remind each other) but where one comes alone, s/he is likely to forget some of the concepts that they were counselled about. But if they come as a couple, they are likely to get a complete package of information and even remind each other on the benefits of FP.
KI, Health provider, Masaka

However, health service providers highlighted a number of challenges faced in providing FP services to men as well as couples. The main challenge was that men had negative attitudes to FP. These attitudes were influenced by desire for large families, religious beliefs towards modern FP methods, and myths and misconceptions of FP. Other challenges reported by one third of key informants were that men were not adequately sensitised and therefore were overridden by fear of the side effects. Side effects (in case they happen to the women) have direct financial implications on the men.

*Men fear side effects. Also men fear vasectomy in case their children all die and they need to have more. Also the male health seeking behaviours are very poor. So we need to increase men's health seeking behaviours. We have tried to sensitize them, created male clinics but they still think it's a waste of time and resources. They are always looking for money for their families. Men also think FP is for women; it is still a problem and I do not know how to deal with it. **KI, Health provider, Mbarara***

*One of the challenges that I am seeing are the attitudes of men towards FP. This attitude is because of the myths about FP. For instance, when we discuss with them, some tell us that if a woman uses FP methods there are chances of getting various cancers, fibroids, even caesarean sections at delivery. Also some of these methods have side effects associated and these have also disinterested some clients. Sometimes we the service providers are to blame. If a mother comes and say she has started on Depo-Provera and may be in the first month she has inter menstrual bleeding, they may not counsel this mother very well, and there you have not managed these side effects well, it is challenge. **KI, Health provider, Masaka***

In addition, health workers reported that there were infrastructural, commodities and personnel challenges at the facilities. There was a challenge of inadequate suitable physical space, inconsistency in supplies of FP commodities, a limited range of modern FP methods specifically for men. There was also an issue of inadequate number of health workers, in some cases only one qualified staff would be available in a health facility and this situation would stifle service provision (outreach, counselling, and routine clinical services for FP). In some cases, our data shows that health workers required more orientation to enrich their knowledge and skills to provide those services

*We are also few health workers here for example as I talk now we are only two midwives and the rest are nursing assistants. For instance, today the midwife in charge is not even around and it is only me who is available for work yet I also have to go on outreach and go to the children's ward which I take charge of as well. **KI, health provider, Lira***

*In my view most health workers focus on women for FP. But, even in communities men tend not to attend the community dialogues. You find only 30% of the mobilized people are men. So it is hard to get them. **KI, programme manager, Mbarara***

*The long-term methods like the implants and IUDs are not here due to lack of trained personnel to offer them. We have very few staff. So when you come and fail to get some of us, just know that this is because we are few in number. We also don't have a specific private counselling room, so we offer group counselling. We rarely provide private counselling for individuals and couples. **KI, Health provider, Lira***

*We lack the brochures to give to the mothers. When they come for services, they go away with nothing for the partner or the community. **KI, Health provider, Iganga***

3.10 Quality of FP services and commodities, and service satisfaction among current FP users

Table 3.9 shows quality of FP services and commodities as perceived by the respondents who used them. Although the majority (85%) of the FP users rated themselves as satisfied with the FP services/ commodities provided in their communities, about a quarter (25%) perceived such services as not being as good as they expected. The highly perceived indicators of quality of FP services included provider competency (86%) based on the way the provider explained the FP methods, ease or understandable FP information (90%) and respect of clients by providers (91%). However 28% of respondents indicated that the providers did not ask for clients FP method of choice; higher among males, 37% compared to only 23% among females, $p=0.0048$, and close to 20% agreed that they would not return for FP services in this community.

Table 3.9: Quality of FP services and commodities, and service satisfaction among current users

	Female		Male		Total	
	Number, n	%	Number, n	%	Number, n	%
Total	221	100.0	88	100.0	309	100.0
Satisfied with FP service/ commodities in community						
Agree	188	85.1	74	84.1	262	84.8
Neutral	21	9.5	7	8.0	28	9.1
Disagree	12	5.4	7	8.0	19	6.1
I do not receive best FP services as expected in community						
Agree	52	23.5	25	28.4	77	24.9
Neutral	24	10.9	4	4.5	28	9.1
Disagree	145	65.6	59	67.0	204	66.0
I would recommend someone for FP in this community						
Agree	201	91.4	83	93.3	284	91.9
Neutral	6	2.7	2	2.2	8	2.6
Disagree	13	5.9	4	4.5	17	5.5
Provider explained FP methods	214	100.0	87	100.0	301	100.0
Agree	187	87.4	73	83.9	260	86.4
Neutral	12	5.6	6	6.9	18	6.0
Disagree	15	7.0	8	9.2	23	7.6
Provider did not ask my choice	211	100.0	88	100.0	299	100.0
Agree	49	23.2	34	38.6	83	27.8
Neutral	12	5.7	7	8.0	19	6.4
Disagree	150	71.1	47	53.4	197	65.9
FP information understandable	211	100.0	84	100.0	295	100.0
Agree	190	90.0	75	89.3	265	89.8
Neutral	13	6.2	3	3.6	16	5.4
Disagree	8	3.8	6	7.1	14	4.7
Provider treat us with respect	215	100.0	88	100.0	303	100.0
Agree	196	91.2	81	92.0	277	91.4
Neutral	15	7.0	6	6.8	21	6.9
Disagree	4	1.9	1	1.1	5	1.7
Would not return for FP service	215	100.0	86	100.0	301	100.0
Agree	42	19.5	14	16.3	56	18.6
Neutral	16	7.4	3	3.5	19	6.3
Disagree	157	73.0	69	80.2	226	75.1

3.11 Efforts undertaken by the CSO's FP programmes to involve men in FP

We established the efforts undertaken by the different CSOs and providers to motivate men get involved in FP with their partners. This was established through the key informant interviews with providers and managers. Most service providers reported that CSOs have efforts in their programmes that to some extent try to involve men in FP. A few however noted that the motivational efforts were not guaranteed to be followed by every staff in the facilities because they were not standard.

The main reported efforts to involve men in FP included: encouraging women to come with their partners, outreach services targeting both men and women, use of appropriate IEC programmes sensitive to both male and female needs, and use of male VHTs to sensitise and encourage men.

In the endeavour to involve men in FP, some CSOs encouraged women to come with partners and such couples would be served first as a motivation. However our data shows that this effort appeared to be a “punishment” for women who could not come with their partners.

*When they (men) come for ANC with their wives we encourage them to come again then we give them health education and at the same time encourage them to get involved in FP, this happens usually on Tuesdays and Thursdays. **KI, Health provider, Lira***

Some CSOs used male VHTs to sensitise fellow men in the communities to encourage them to use and support their partners in the use of FP. This approach was reported to be successful particularly to The AIDS Support Organisation (TASO).

*We have male and female community mobilisers who help us to publicise our work and promote service utilisation. However, we note that although we have both men and women, the women prefer to talk to fellow women about FP and men also find it easier to talk to fellow men. For example a woman would be shy to talk to men about vasectomy. **KI, Health provider, Mbarara***

4. DISCUSSION

The mean household size was 5.8 persons per household which is higher than the national average of 4.9 (Uganda Bureau of Statistics and ICF Macro 2012). Specifically, Eastern region had the largest household size (7.2) while the Central (4.1) and South-western (4.5) had the lowest. This could be explained by the high fertility level in Eastern Uganda. Thirty six percent of the households had children below 15 years, which reflects the national population structure. It should be noted that half of the respondents belonged to households in the lower social economic status. This indicator was based on use of modern house construction/ building materials (such as iron sheets/tiles, cement for both the walls and floor). West Nile (82%) and eastern (80%) regions had the highest proportion of households in the lower socioeconomic status, while the central region (12%) as expected had the lowest.

In this study, although slightly over half (53%) of the respondents used FP method at the last sexual encounter, only 45% had either a male condom used, or a male partner discussed or contributed to the decision to use FP method thus being classified as having male-involvement in FP. These data therefore show that level of male involvement in FP is modest. Use of female controlled FP methods (39%) was higher than the Uganda national modern FP, 30%, but only 12% of FP use was male controlled methods only. Including FP discussion with the partners to form a composite measure of male-involvement with both discussion/partner decisions and use of male-controlled method increases male-involvement rate to 45% at the last sexual encounter. This finding shows that a great component of male-involvement is due to male partner involvement in decision making of what FP method to use by the sexual partners. The limited role of male-involvement in actual use could be explained by the limited range of modern male controlled methods (male condoms). However, the reported male-involvement in discussing or contributing to the decision to use a female controlled method shows a positive step forward in ensuring that males also play a role in the issues of sexual and reproductive health, especially family Planning. It is therefore possible that enhancing spousal/ partner discussion through spousal communication programs/interventions in sexual health matters may further increase male-involvement in FP. A study in Nepal (Cynthia F 2011) already provided similar evidence of the impact of spousal communication on male involvement. It showed that as wives report more frequent FP discussion, the monthly odds of condom use increase by 45 percent while for the male partners for each additional unit increase in the measure of family planning discussion from the husband's perspective, the monthly odds of

condom use increase by 106 percent. Fertility desires have also been found to reduce couples' fertility intentions/desires in Nigeria(Kolawole Azeez Oyediran and Isiugo-Abanihe 2002).

Although male-involvement with the last sexual partner was 45%, when the definition was made general with reference to any sexual partner in the past 12 month, this rate was significantly reduced to only 35%. This observation shows that the approach used to determine such outcomes will depend on how questions get asked. Male-involvement with the last sexual partners may be a better estimate because this measure minimizes recall biases and also minimizes the potential of a respondent to "average" their responses over multiples partners they had sex with in the reference period.

Males reported higher condom use for FP (27%) relative to females (7%), while a higher proportion of females reported higher use of hormonal methods relative to what males reported about their partners. This is expected since male condoms are the main male controlled modern method of contraception, while hormonal contraception includes injectables which are the main female controlled method in Uganda. In many circumstances women have been found to use FP methods without their partners' knowledge, especially when the partner is disagreeable to FP or specific method. A third (31%) of the pregnant females or male who reported pregnant spouse at the time of the survey said that they were using FP method at the time of becoming pregnant. This could be due to either FP methods failure or due to inappropriate use of the contraceptives by the couples. About 1 in 5 (22%) respondents reported use of non-modern method at the time of becoming pregnant (breast-feeding, 7% and herbs/traditional medicine, 15%). Such FP methods are not efficacious thus the observed high rate of pregnancy among users of non-modern methods. Use of these non-modern methods may be attributed to either lack of FP commodities/services in the communities, or as a methods choice. It has been observed in this study that some women have either actual or perceived side effects when they use modern methods. It is therefore important that FP commodities/service providers need to provide enhanced counselling to such women so that they continue to use alternative but efficacious choices that may reduce the side-effects, else the rate of unplanned pregnancies due to method failure may increase.

Respondents' perceptions and beliefs about FP services and quality of FP services in the communities that may affect male involvement were determined in this survey. a third (32%) of the respondents, especially females do not find it easy to discuss sexual matters with their partners or perceived that FP is for females only (24%). In the 2006 UDHS, 45% of married women had never

discussed FP with their partners in the last one year (Uganda Bureau of Statistics and Macro International Inc. 2007). Although there were no reasons given for this, it could be that these perceive it as a female concern or were uncomfortable talking to their partners about the same as reported here. However majority (86%) perceived that couple FP counselling would improve male involvement in FP, agreed that FP benefits males too (88%) and community acceptance of FP was high (78%). Female participants in FGDs indicated a desire that their male partners should participate more in FP activities. In assessing the role of FP in HIV prevention, males perceived FP as relevant especially through male condoms.

Majority of respondents (85%) perceived FP services in the communities as being satisfactory as well as having high provider competency. However the inability of the providers to ask clients about their FP choice point to some indicators of quality of care that should be addressed. Health workers had positive attitudes about male involvement, and the CSOs also endeavoured to involve men in FP, but with varying strategies across CSOs.

In the conceptual framework that guided the study, factors affecting male involvement in FP were viewed largely in terms of personal, community and health service factors. However it is important to note that some factors could be both personal and at the same time possess community characteristics and therefore hard to extricate.

This study established that male involvement in FP increased in a non-marital relationship (adj.RRR 1.94; CI: 1.14, 3.32), having been talked-to about FP (adj. RRR 12.72 CI: 1.71, 4.33) potentially a measure of FP awareness, and awareness of HIV/AIDS services in the community (adj. RRR 1.42(0.95, 2.12)) higher level of schooling- post primary (adj. RRR 2.05(0.85, 4.94)), and possession of modern items such as mobile phones tended to be associated with increased male-involvement in FP (table 3.7). Having been talked to about FP or being aware of HIV services in the community may be an indicator of better health/knowledge seeking behaviours. This information may have been obtained from community health education sessions provided by CSO in community outreach meetings. Also, the other potential sources of such information may be through visits at various health facilities where the individuals get to learn about FP. Findings in this study already indicate that 51% of the respondents obtained their FP methods from public health facilities. If the sources of the FP were also the sources of the FP knowledge or awareness of HIV services, then these sources should continue to be used to promote FP and male involvement in FP. Having been “talked to” about FP by any one may also have been peer-peer discussions which then strongly

suggest a need to promote peers or agents of change. Personal communication about FP matters to men is important because it allows deeper discussions and clarity of information about FP.

Increased male-involvement in FP and being “aware of HIV services in the community” is consistent with the use of male condoms, most commonly reported by males. The male-condoms which are mostly mentioned by males as FP method also have a dual role in HIV-prevention. Increased male condom-use as FP is also associated with “awareness of HIV services in the community”. Also, majority of respondents (88%) agreed that FP benefits males too, and this understanding of male benefit could be attributed to the dual nature of the male-condoms. Therefore the linkage between FP and HIV suggests a need to integrate these services so as to further promote and strengthen FP in the communities. It is also important to note that 23% of respondents reported likely to be HIV+ (females 25% and males 15%). This perceived HIV status varied by region being highest in East-Central (36.9%) and the North (35%) and lowest in West-Nile (10%) and South-West (14%). Such high levels of perceived HIV+ status may indicate that either respondents know their actual HIV+ results after accessing HIV services or have been counselled for HIV.

The increased male-involvement in non-marital unions may be explained by fear to become pregnant or getting infected with HIV or avoiding re-infection for those already HIV+. The findings in this study indicate that 25% of males whose last sexual partner was non-marital perceived themselves to be HIV+, or perceived that their partner was HIV+ (25.4%) or did not know partner’s sero status (40%). Therefore lack of knowledge about partner’s HIV sero status or high perception of HIV+ partner status may explain the higher use FP methods or male involvement among non-marital partnerships. This finding is encouraging because the partners can avoid unplanned pregnancies and STI/HIV/AIDS. CSOs should continue to provide these messages.

Increased levels of education as reported to positively influence male involvement are also well known to be determinant of fertility because education creates awareness, delays childbearing and also empowers individuals especially women to possibly discuss sexual matters such as FP use and negotiate with improved communication skills in matters of sexuality (Alpu and Fidan 2006; Odu, Ijadunola et al. 2006; Saleem and Pasha 2008). Since the government offers free universal primary and secondary education, CSOs and other stakeholders should encourage communities to ensure that their children enrol and get retained in school. CSOs could operationalize this by including school enrolment and retention mobilization/campaigns as part of their activities in the communities

they operate. In addition, the long-term strategy may involve a review of school curricula to include appropriate syllabus on FP and sexuality that may further promote male involvement in FP.

Being in a marital disruption (divorced/separated/widowed) (adj. RRR 0.26; CI: 0.10, 0.73), large family size - 6+ co-resident children aged less than 1, 5 years (adj. RRR 0.48; CI : 0.25, 0.95) and low social economic status adj. RRR 0.56, CI: 0.32,0.98) were important barriers to male-involvement. Men and women in marital disruption (divorced/separated/widowed) may not have power to negotiate sex and thus reduced male-involvement. Individuals in this category need to be empowered like the never-married in negotiating for sex. However, they also tend to be of lower level of education as well as poor SES. Respondents with large families (6+) may be the poor less educated with little or no negotiating power. CSOs and other stakeholders may need to engage the poor families or individual with an experience of marital disruption through economic empowerment. Stakeholders like World Vision (WV) have previously provided support to such individuals organized in small groups, with a purpose of economic empowerment that could increase their negotiating power.

Belonging to Pentecostal or SDA religions compared to being Catholic appeared to lower the chances of male-involvement in FP (RRR; 0.59 CI: 0.36, 0.97). In this study Pentecostals and SDA also tended to not use any FP method. However, those who used FP did not report male-condoms as FP method of choice. Male-condoms have been promoted as HIV-prevention strategy more than FP method. Pentecostal/SDA individuals may perceive male-condom users as being promiscuous and this deters their use among the members. CSO may need to engage the religious leaders through the inter-religious council as a means of promoting FP and male involvement.

Poor knowledge, perceptions and beliefs about FP are still a strong deterrent to male-involvement in FP. The high level of belief that FP is for females only (24%) in communities already receiving FP services offered by CSOs shows how strong beliefs and perceptions may be hard to deal with in order to effectively impact on communities receiving such services. Although a very high proportion of respondents (88%) agreed that FP also benefits men, it was not clear what the respondents understood or meant by such benefits. However, the use of male-condoms for prevention of both HIV and pregnancy may explain why respondents report that FP is also beneficial to men too, yet there is poor male-involvement in FP. So it is men who perceive themselves to be at increase risk of HIV who may take up FP (but as male condom use).

Qualitative results in this study revealed that men knew mainly hormonal and barrier FP methods. However there was fear of side effects for their spouses from modern methods. Besides, the males were very worried of their relationships. They perceived that FP promotes promiscuity reasoning that women are unlikely to get pregnant while on contraception. In fact, some men explicitly indicated that contraception gives women “an open passport” to promiscuity- “they ‘sleep around’ easily since the worry of pregnancy is not there”. The issue of promiscuity is an old perception in Uganda. Nakato established that there were general fears mainly from men about contraception include the notion that contraceptive use encourages promiscuity in women (Nakato 1994) and in central America (Schuler, Choque et al. 1994)

This could point to limited comprehensive knowledge about FP methods even though mention of methods is high as noted in some studies elsewhere in Africa (Odu, Ijadunola et al. 2006; Bunce, Guest et al. 2007). Such could also partly explain the persistently high fertility levels in Uganda of 6.2 children per woman (Uganda Bureau of Statistics and ICF Macro 2012).

The negative views about FP methods expressed in this study were also found in West Africa where attitude to FP were poor as only half of the men supported the FP (52%) (Odu, Ijadunola et al. 2006). Even still the misconceptions transcend from clients to health workers who possess fears about contraceptive use (Nalwadda, Mirembe et al. 2010; Nalwadda, Mirembe et al. 2011) . With low male involvement in FP, it is postulated that only a few couples discussed FP. Lack of open discussion about FP could in-fact be one of the reasons why women ‘secretly’ go for injectable long acting method (depo provera). This trend has also been observed in the horn of Africa (Beekle and McCabe 2006) Efforts to enhance couple discussion are critical. This could be through couple counselling as observed in central Uganda (Kaida, Kipp et al. 2005) with use of various social and community factors; Churches, mosques and social gatherings could be used to promote male involvement in FP. For example in the Buganda region, there is the “Ekisakaate” cultural event while in the western region of Uganda, there are community insurance social schemes (Ebibina byengozi) could be instrumental in channelling information about the need for male involvement in FP.

In terms of partner involvement, qualitative results highlight that females wished their partners to be involved in FP and using male methods. However, the vasectomy was disliked because women still held misconceptions like fear of making males impotent or reducing their performance as a result of the procedure. This view was also established by other studies (Ozvaris, Dogan et al. 1998; Bunce,

Guest et al. 2007). Withdrawal which is a male controlled method was among the few available FP methods practiced. It was however thought to be cumbersome to implement rendering it ineffective.

This study hypothesised that health service factors affected male involvement in the conceptual framework. These results demonstrated that health service providers were positive about the interventions involving men notwithstanding the challenges faced. These challenges included poor infrastructure, inadequate skills in providing a range of FP services, non availability of contraceptive commodities and a very short range of male methods of FP. Further it should be noted that there were some deliberate efforts in place by CSOs to encourage men to participate in health activities including FP.

Although majority of respondents perceived FP services in the communities as being satisfactory as well as provider competency, quality indicators not favourably ranked including providers inability to ask clients about their FP choice, and the 1 in 5 clients not willing to return for FP services in the community point to key issues in quality of services that should be urgently addressed. Health workers/providers may not have the whole range of FP commodities available FP. However, this should not limit them from explaining to the clients the various options so that they can make an informed decision and choice. If clients make their choices of FP, this may increase male-involvement in FP. This finding may require CSO and providers to increase to scope to available FP methods so that clients can choose what best satisfies their situations as this will certainly include male partners in decision making. In the qualitative study, vasectomy appears to be unpopular even health workers. For example a study done among male health workers in Nigeria revealed that about 6 in ten (58%) were unwilling to accept vasectomy as a contraceptive procedure (Okunlola, Awoyinka et al. 2009). However, on the whole, health facility factors do not appear to be a major barrier to male-involvement in FP.

Finally, this study identifies a strong need to increase FP in communities and populations served by CSOs. Just about half (55%) of the female respondents or partners of the male respondents who were pregnant at the time of the interview either wanted to limit childbearing (44%) or tried to terminate the pregnancy (11%). These observations are a strong indication for lack of FP use or contraceptive failure in this population. The proportion trying to terminate a pregnancy is an underestimate because abortion is illegal in Uganda. Therefore CSOs should ensure that FP is promoted and made available to every woman and man who needs these services.

Strengths of the study

The sampled household characteristics and the age and sex distributions of the study population are similar and consistent with findings in the UDHS 2011. The consistency of responses between male and female participants on responses applicable to both sexes further strengthens the data quality and potential reliability of this study. For example, like other studies, multiple sexual partnerships (MSP) are common and prevalent among males compared to females, and the prevalence of pregnancy as reported by female respondents or by male participants about their female partners was very similar. These consistencies provide credence for the potential generalization of the study findings.

Challenges and limitations

This study was conducted in 15 districts of Uganda and used a minimum of 8 languages. There were challenges in translation of the field tools into all the languages to perfection before data collection was commenced. In some districts such as Masindi, Hoima and Busia, one could find three to four languages being used. This was however overcome by having research assistants who were proficient in several languages and were also closely supervised.

Data collection phase took place in a rainy season in most parts of the country. This led to accessibility problems in some districts especially in Eastern Uganda. This negatively affected the planned resources (transport, and time in the field).

Some of the CSOs were not fully known in the communities. This was because they were working through other organisations. The research teams took a lot of time trying to locate them and in some cases the interviewees were not readily available. Besides, some CSOs had just started out in some areas and were not known by the community.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusions

- The level of male involvement in FP was moderate (45%) and considerable regional variations.
- Awareness about HIV care services availability in the communities, knowledge of FP and higher level of schooling (post primary) were associated with higher level of male-involvement in FP.
- Community perceptions about FP were largely positive although FP is still viewed as being beneficial to women only. Males viewed the role of HIV prevention in FP as being important, partly because the male condom is dual method.
- The misconceptions about modern FP methods were high in the communities. Perceived and actual side effects experienced by FP user negatively affected male attitudes towards FP methods used by women.
- Women expressed a desire to have the partners involved in FP activities including use of male methods. However, male methods are few in range and yet some methods such as withdrawal are hard to implement and vasectomy was not a popular. Joint decision making about FP was preferred.
- Health providers had positive attitudes towards involving men in FP activities, and some CSOs have endeavoured to involve men in FP activities
- FP services/commodities provided in the communities were perceived as being satisfactory and provider perceived as competent by majority of respondents (90%). However there are some key unfavourably perceived indicators of quality of FP services such as inability of providers to ask clients about their FP choice that need to be addressed.

5.2 Recommendations

- CSOs need to positively change community perceptions among men about FP and educate communities more on how it benefits both the men and women. This could be done through community engagements right from opinion leaders to the different layers of stakeholders and the peer to peer approach. We recommend the peer to peer approach because it fosters personal and sensitive information to easily be shared and diffuse among men. These informal and inexpensive peer networks allow gradual and continuous acquisition of information.
- Engagement of stakeholders such as the inter-religious council should be more strengthened as this may be the entry point to address the non-use of male—condoms mainly by the Pentecostals/SDA
- The strong association between awareness of the HIV services and male-involvement in FP strengthens a need to integrate these services so as to further promote and strengthen FP in the communities. This can be done by use of successful community based approaches such as use of male VHTs that were found to be successful by TASO. It is recommended that TASO should share their experience among other CSOs through various ways including exchange visits and resident mentorships among CSOs.
- There is need to further educate the FP users on possible expected side effects and how to manage them. For the health workers, there should be openness and truthfulness about the expected side effects. This will enable FP clients become psychologically prepared and make an informed decision to use FP methods. Continuous education about advances in FP technologies should be encouraged to enable health workers attain a clear understanding and appreciation of the methods they provide to clients.
- Higher level of schooling (post-primary) could be achieved in the communities by CSOs participating in activities that will ensure increased school enrolment and retention through mobilization/campaigns as part of the CSO activities in the communities they operate. This may appear to be a long term strategy, but it is important and can have sustainable long-term effects on male-involvement in FP
- Facilitating health workers to conduct FP outreach services should be prioritised. This was reported as one of the efforts undertaken by CSOs to involve men in FP but was stifled by

limited staffing. Strengthening outreach should be done through increasing staffing levels, providing access to transport and IEC materials targeting men.

- Since qualitative data showed that FP services are female centred, there is need to make facilities friendlier to men who wish to get more information and FP services.
- CSOs should promote couple counselling for FP since there was evidence that respondents believed that couple counselling approach improves male involvement. This will increase /promote joint decision making for FP among couples. Couple FP clubs could be formed based on the model used by HIV post test clubs for the HIV+ clients

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